KNOWLEDGE AND ACTION IN NURSING:

A CRITICAL APPROACH TO THE PRACTICE WORLDS OF FOUR NURSES

A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Nursing at Massey University

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ABSTRACT

This thesis provides an interpretive critique of the way in which knowledge is viewed, transmitted and crystalised in the practice worlds experienced by four registered nurses working in acute care hospital settings. The theoretical assumptions of critical social theory underpin both the methodological approach (case study) and the analysis of data. In-depth, unstructured interview, a critically reflexive dialogue between the investigator and participant focussed on the practice world experiences of the nurse, was the principle research method. A brief analysis of documentation was also undertaken.

It is argued that previous studies related to nursing practice, and to the social worlds of nursing, have been limited by their failure to take account of the socio-political context in which nursing takes place. There has also been a tendency to treat the transmission of knowledge in nursing and nursing practice as a passive process of information exchange. No account of socially generated constraints on personal and professional agency, or of systematic distortions in communication within the practice setting are therefore given.

The analysis of data in this study demonstrates the way in which constraints on personal and professional agency were experienced by each of the four participants. In particular, practice expressing the participants' professional nursing knowledge and values was often denied in the face of shared understandings reflective of the institutional ideology. These shared understandings included a belief in the legitimacy of medical domination over other social actors and the support of doctor, rather than nurse or patient, centred practices.

The study demonstrates that the way that nurses and other social actors come to 'know' and interpret their social worlds is dependent on the socio-political context in which that knowledge is produced. It also shows how this knowledge may be treated as though it were 'an object'. This tendency to treat existing social relationships and practices as 'natural', hence unchallengable masks possibilities for transformative action within the practice of nursing.

It is argued that a particular form of knowledge is required if nurses are to overcome the types of constraint experienced by these four nurses. This knowledge, emancipatory knowledge, is that developed in the process of shared, socially critical self-reflection rather than solitary, self-critical reflection.

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PART ONE

CHAPTER ONE

INTRODUCTION AND OVERVIEW

The Nursing Tradition

The nursing profession in New Zealand, in common with nursing in much of the rest of the world, has emerged from a long apprenticeship tradition. The image perpetuated in this form of preparation was one of endurance, forbearance and obedience - what Rodgers (1985) terms the 'Nightingale ethos'.

Formal nursing practice occurs predominantly within bureaucratic organisations. Nurses are the largest single grouping of health workers and perform much needed services for the community. As such nurses are potentially a powerful group of health care providers. Nurses have however traditionally been, and still are in many respects, accorded a low status relative to other health professionals, in particular the medical profession.

The introduction of Comprehensive nursing courses occurred in New Zealand for the first time in 1973. This was a move away from the traditional apprenticeship form of preparation for nursing in general, psychiatric or psychopaedic hospital schools of nursing, to broad courses based in educational institutions. There was some expectation with their introduction that this may hasten the move of nurses beyond their traditional image to an image of professionalism encompassing fully the notions of autonomy and accountability in the provision of nursing care.

In recent times internationally, and to a lesser extent in New Zealand, there has been a rapid increase in the amount of research being undertaken by nurses. Many different aspects of nursing practice have been studied with a view to building and articulating the knowledge base of nursing.

In this chapter literature examining some aspects of the practice of nursing is reviewed. In particular, the large body of research relating to the preoperative and preprocedural preparation of patients and patient education in general is examined. This literature review

is used to identify and illuminate limitations and areas of deficiency in much existing research in this area.

These limitations are primarily in terms of assumptions made, content of studies and types of study. They include the almost exclusive reliance on experimental, quasi-experimental and survey designs, the failure to take account of the socio-political context of nursing, and treating the transmission of knowledge as a passive process of information exchange. These limitations provide the impetus and basis of this present study which examines the experienced practice worlds of four registered nurses and, in particular, their views of knowledge and action and the transmission of knowledge in the acute care settings in which they work.

Preoperative and preprocedural patient preparation

The area of patient education provides examples of the way in which nursing and other researchers have largely ignored consideration of the socio-political conditions in which nursing occurs. Prescriptions for practice are often developed from the results of these studies but it is not surprising that they often find little expression in the actual practice worlds of nurses.

The provision of information by health-care professionals to health-care recipients, and the effects of this, has been the focus of a considerable (and expanding) body of nursing literature. For example, a large number of researchers have examined the relationship between various types of preoperative and preprocedural preparation that includes the provision of information and/or instruction and postoperative or postprocedural outcomes for patients. While there are some inconsistencies evident in the results of these studies positive effects have been demonstrated using a variety of physiological and affective measures. These have included, for example, reductions in:

* anxiety (Schmitt & Wooldridge 1973; Lindeman & Stetzer 1973);
* biochemical indicators of stress and infection rate (Boore 1976 cited in Boore 1977);
* muscle tension and/or self-reported pain (Hayward 1975; Wells 1982);
* distress caused by painful sensations (Mogan, Wells & Robertson 1985);
* length of hospitalisation and length of time posthospital discharge before patients ventured from home (Johnson, Fuller, Endress & Rice 1978b);

- delirium (Owens & Hutelmyer 1982);
- postoperative vomiting (Dumas & Leonard 1963);
- anaesthetic and/or analgesic requirements (Egbert, Battit, Welch & Bartlett 1964, Schmitt & Wooldridge 1973, Fortin & Kirovik 1976);
- urinary retention (Schmitt & Wooldridge 1973) and
- respiratory function impairment (Ozbolt Goodwin 1979).

Meta-analyses of many of these studies have been undertaken by Devine and Cook (1983) and Hathaway (1986). The former analysed 49 studies examining the relationship between brief psychoeducational interventions and the length of postsurgical hospitalisation. The latter examined 69 studies of the effect of preoperative instruction on postoperative outcomes. Both concluded that preoperative interventions of this kind had a favourable effect on postoperative outcomes.

Much attention has been directed towards establishing the most effective type of preoperative and preprocedural preparation, for example, the provision of factual information, encouraging patients to talk about their feelings, instruction in relaxation techniques or exercises, and various combinations of these. (Mogan et al. 1985; Wilson 1981; Hill 1982; Ridgeway & Mathews 1982)

Other studies have directed attention towards establishing:

- the most effective methods and context of instruction, for example structured or unstructured instruction (Lindeman & Van Aeram 1971; Felton, Huss, Payne & Srsic 1976; King & Tarsitano 1982), group or individual instruction (Lindeman 1972) involvement versus noninvolvement of the family in instruction (Dziurbejko & Larkin 1978);
- the most useful types of information, for example, sensation or procedural (Johnson, Fuller, Endress & Rice 1978a; Hartfield & Cason 1981);
- the most appropriate timing and duration of preparation (Fortin & Kirovac 1976; Lévesque, Grenier, Kérouac & Riedy 1984);

* and the relationship of personality and psychological variables such as preoperative fear, anxiety (trait or situational) and/or coping style to recovery and/or effectiveness of preoperative or preprocedural preparation (Janis 1958; Andrew 1970; Cohen & Lazarus 1973; Sime 1976; Kinney 1977; Shipley, Butt, Horwitz & Farby 1978).

In common with much research that has been undertaken in relation to the practice of nursing, most of these studies have been experimental or quasi-experimental. The actual perceptions of patients and those seen to be responsible for such preparation have been less consistently studied. What little there has been has been largely in the form of surveys aimed to determine the perceived adequacy of the information provided or understood.

While it is clearly acknowledged by many writers that communication and information provision are two of the most important aspects of patient care, surveys of patient perceptions have shown that there is significant levels of dissatisfaction with these areas. (Ley 1977; Reynolds 1978; Hentinen 1983; Engström 1984; Stanton, Jenkins, Savageau, Harken & Aucoin 1984; Moores 1986). Relating previous studies to her own findings Engström (1984) comments:

> ...the patients' dissatisfaction with information in connection with hospitalisation appears to be a general problem, which has not changed over a period of 20 years. (p.125)

Some studies have sought to determine the views of patients and/or their relatives regarding the type of information that should be given to prepare them for their experiences (Weiler 1968; Derdiarian 1986). Others have examined the level of coherence between nurses' and patients' perceptions of the informational requirements and/or the educative role of nurses. (Carlson & Vernon 1973; Lauer, Murphy & Powers 1982; Schuster & Jones 1982; Tilley, Gregor & Thiessen 1987). Patient recall of information (Ley 1979; Reading 1981) and variables seen to influence the effectiveness of education and information provision, for example, the reading levels of patients (Glazer-Waldman, Hall & Weiner 1985) have also been examined.

Often writers point to nurses as, actually or potentially, key information-providers, and to patient-teaching as a significant part of nursing responsibilities. For example, King & Murphy (1983) note:

> Nurses are in an excellent position within the health care system to participate in the development, implementation and evaluation of programmes designed to help patients cope with aversive medical procedures. (p.10)

However, while researchers continue to direct their attention towards establishing the most effective means of preparing patients for their hospital experiences, and of providing them with relevant information, minimal attention has been devoted to the experience of nurses in relation to such preparation. In particular, the extent to which nurses feel able to act as information-providers has been left largely unexamined.

Barriers

The aim of many studies has been to develop more effective nurse-patient interactions. In doing so identified deficiencies are seen to be simply technical or educational problems. Solutions therefore are seen to lie in technical manipulation or educational interventions. There is a tendency to see the 'cause' of ineffective practices as residing in the nurses who fail to communicate effectively with patients. For example, in a review of research and non-research based literature related to patient education Close (1988) identifies a number of barriers to effective patient education. These are nurses' lack of:

* Knowledge about the content of teaching;
* Communication skills;
* Assessment skills and
* Teaching skills.

She also notes that there is evidence that nurses:

* Assign low priority to educating patients and
* Are not recognised by patients as a source of information or as someone who can and does teach them.

All of these can be seen to be individual 'deficiencies' of either the nurse or the patients and are assumed to be amenable to educational manipulation.

Wilson-Barnett & Osborne (1983) also locate the major barriers to patient education within individuals. They comment:

> There may be many reasons why nurses do not teach patients... probably nurses are unaware of patients' needs for information, which remain unexpressed and unsatisfied... perhaps nurses lack confidence and knowledge on what to teach. (p.42)

It is generally assumed that, were they better educated with regard to the content and processes of patient teaching and communication skills, nurses would be able to interact with patients effectively. Syred (1981) for example notes that:

> (although)...nurses are in a unique position to influence patients and so carry out health education... many nurses appear to abdicate this role.

She suggests that:

> ...the nurses' own education has failed to equip her with the skills necessary for the fulfilment of this role. (p.27)

Research in this area generally treats as unproblematic the social conditions in which such interaction occurs. Complex social reality is reduced to consideration of individual variables seen as characteristics residing in particular individuals or groups. Likewise solutions are seen in the manipulation of individual variables such as the educational state of nurses. Omitted is consideration of social structures and processes of social interaction. Without such an analysis it is not surprising that much research finds little expression in the actual practice settings of nurses.

In most of the studies and writings referred to above the transmission of knowledge is taken-for-granted as largely passive process of information provision. In doing so the socio-political control of knowledge, and the ways in which in distorted communication patterns feed into shared understandings perpetuating existing social relationships have been largely ignored.

In the 1980s nurses have begun to articulate the knowledge embedded in the practice of nursing. Benner (1984) for example uses an interpretive approach to examine the knowledge embedded in nursing expertise. She notes:

> ...the knowledge embedded in this clinical expertise is central to the advancement of nursing practice and the development of nursing science. Not all of the knowledge embedded in expertise can be captured in theoretical propositions, or with analytic strategies that depend on identifying all the elements that go into the decision (Benner & Benner 1979). However, the intentions, expectations, meanings and outcomes of expert practice can be captured by interpretive descriptions of actual practice.
>
> (Benner 1984: 3-4)

This approach while it makes important contributions to the knowledge base of nursing again omits overt consideration of the broader social conditions in which nursing occurs. While such approaches may distinguish what the practice of nursing is and articulate some of the knowledge on which it is based it does not help significantly in distingiuishing why practice is as it is.

The social world of nursing

While many studies examining the practice of nursing have failed to give consideration to the social context in which it occurs, others have set out specifically to examine various aspects of the social world of nursing. In particular, many studies have sought to examine various aspects of the 'nursing role' and the socialisation of nurses into the professional nursing culture.

While these studies have gone some way to elucidating the experienced social world of nursing most have been limited by the adherence to methodologies and interpretations arising out of restrictive conceptions of what can be taken to count as legitimate knowledge within the dominant empirico-analytic and, more recently, historico-hermeneutic scientific paradigms (refer chapter 3, pp.23-28).

For example, studies of the 'role' and/or the professional socialisation of nurses carried out from within an empirico-anlalytic framework (for example, Chick 1975 and Miller 1978) often seek to provide causal explanations for the ability or otherwise of students and graduates to 'fit' the institutionally defined nursing role. Social structures are largely taken-for-granted and the student or graduate becomes the focus of findings and recommendations.

Incongruity experienced between the social structures and expectations of the institution and the expectations or actions of student or graduate are explained in terms of the

individual. For example, Miller (1978) uses the notion of 'role deprivation' as an explanatory construct in analysing incongruities between the bureaucratic demands of the institutional organisation and the professional role conception of the nurse. Facilitation of the 'adaptation' or 'adjustment' of the nurse to the pre-existent institutional structures is the basis assumed in much research of this type.

While the focus of the above research is on the adaptation of the individual nurse, research carried out within historico-hermeneutic frameworks (for example, symbolic interactionist or phenomenological approaches) is focussed on providing an understanding of the meaning and intentions attached to particular behaviours of, or situations experienced by, social actors.

Particularly since the late 1970s research reflecting the assumptions of this paradigm (for example, Thomson, Kinross and Chick (1977) and Buckenham and McGraths' (1983) study of the 'social reality of nursing') has been carried out by researchers seeking to explore the professional socialisation and social interactions of nurses. Such studies remain essentially conservative in that, again, social structures and relationships are largely taken-for-granted, and the individual perceptions of nurses, the meanings attached to particular practices, and the understandings of the individual in relation to the social organisation and structure become the focus of concern.

Few studies have fully taken into account both individual agency and social structure, and the relationships between these, in examining social world of nursing. Two notable exceptions are Menzies (1970) and Perry (1985).

The study by Menzies, originally carried out in the late 1950s, set out to account for the high levels of stress and anxiety said to be chronic amoung nurses. In the course of the study Menzies noted that the nurse's task was not of itself enough to account for the level of anxiety and stress observed. Consequently an attempt was made to understand and evaluate the effectiveness of the methods the nursing service provided for the alleviation of anxiety (the social defence system). She concluded that the social structure of nursing was defective as a means of handling anxiety in that the social defence system

> ... represented the institutionalisation of very primitive psychic defence mechanisms, a main characteristic of which is that they facilitate the evasion of anxiety, but contribute little to its true modification and reduction.
>
> (Menzies 1970: 38)

This study was significant in that it attempted to relate the social structure of the institution to the individual agent, the nurse. However, the focus of the recommendations remained the individual nurse in exploring how institutional practices could better facilitate anxiety reduction in the nursing staff. How the social structure itself might change was not addressed.

Perry (1985) in her examination of the induction of five graduate nurses into the professional culture of nursing used a socially critical approach to move beyond the inherently conservative approaches of previous studies of professional socialisation. The study involved a critically reflexive analysis of the perceptions of new graduate nurses working in a hospital setting. This analysis was used to explore the ways in which social forces constrain individual and professional action.

Recommendations arising from this study were focussed largely on educational implications. A more critical approach to the design of nursing curricular was advocated and assumed to provide opportunities for some of the structures which were seen to inhibit and constrain professional choices and actions of student and graduate nurses to be transformed. The possibilities for transformative action within the practice settings themselves were less clearly explored.

Thesis outline

It is argued here that the practice of nursing cannot be understood without some critical consideration of the socio-political conditions and relationships in the settings in which it occurs. The present study aims to contribute to a greater understanding of this apparently taken-for-granted aspect. It therefore seeks to describe, explore and critically examine four nurses' views of themselves in relation to knowledge and action and the transmission of knowledge in the acute care settings in which they work. Case study, utilising a socially critical approach, is used to go beyond the descriptive and explanatory types of study

described above and provide a reflexive critique of the practice world experiences of these four nurses.

The thesis is divided into three parts. **Part One** (chapters 1-4) provides a general introduction to the study, the guiding theoretical perspective, the chosen methodology, and specific procedures followed.

Following on from the conclusions reached in **chapter one** regarding the limitations of previous research relating to the practice of nursing, **chapter two** provides an outline of critical theory, and of the concepts, used in the analysis of data, such as 'ideology', 'systematically distorted communication' and 'hegemony'. The way in which such a socially critical perspective adds to the understanding of the practice world experienced by the four study participants is discussed.

In **Chapter three** Case Study as a research approach is discussed generally. Consideration is given to the way in which case studies have been viewed, and the contribution the approach is seen to make within empirico-analytic and historico-hermeneutic scientific 'paradigms'. The particular way in which it is used in studies utilising a socially critical perspective is also outlined.

Chapter four provides a description of the procedures followed in this present study. Ethical considerations arising from the nature of the study and precautions taken to protect the rights of the research participants and others potentially affected are discussed.

In **Part Two** of the thesis the data and analysis is presented. In **chapters five to eight** selected interview data is presented along with a theoretical commentary. A synopsis of this and a brief participant profile is provided at the beginning of each of these four chapters.

Part Three (chapters 9 & 10) consists of an integration of the theoretical analysis presented in the preceding chapters with subsequent conclusions. In **Chapter nine** shared understandings and interpretations of the participants' experiences of their social worlds are identified and discussed with reference to the theoretical concepts described in chapter two. In the final chapter (**Chapter ten**) implications for practice and education are discussed. Limitations of the present study are identified and recommendations for future research are made.

CHAPTER TWO

CRITICAL THEORY

The methodology, analysis and ethical precautions taken in this study have been determined largely by the use of a socially critical approach based on the ideas of the German philosopher Jürgen Habermas. The theoretical base for the study is explained in this chapter. In addition theoretical concepts used in the later analysis will be identified and discussed.

The chapter begins with a brief discussion of the foundation and nature of critical theory in social inquiry. Secondly some of Habermas' major theoretical propositions are presented and the implications of these propositions for scientific inquiry discussed. Next some of the criticisms levelled at Habermas' work and the possible limitations of such approaches will be discussed. Lastly, the appropriateness of this particular form of inquiry to the present study will be established.

Knowledge

One way in which knowledge has been conceived is as:

> ...the product of contemplation...best achieved by disinterested individuals, passively perceiving some aspect of reality, generating verbal representations to correspond to it. Such descriptions, where valid, match reality...
>
> (Barnes 1977: 1)

By this account knowledge is a product of the contemplation of isolated, disinterested, interchangeable individuals and is seen to be independent of the historical, social and political context in which it is produced. It is assumed that there is a direct correspondence between reality and the representation of that reality. Reality is therefore taken to be static, fixed and immutable.

Increasingly the above account has been rejected particularly by social scientists working within a socially critical framework. Recognition is given to the notion that knowledge is necessarily embedded in social practice. Knowledge is seen as being simultaneously :

- formed in action
- realised in action
- and informing action, that is to say, making action comprehensible.

Knowledge is seen as being produced within particular historical/ socio-political contexts, a product of social negotiation. It is not separate from, but arises out of, human activity and interests and as such is highly political.

Paulo Freire is one of a growing number of writers who stress this social dimension of knowledge. He notes: 'Knowing is the task of Subjects not objects' (Freire 1974: 99) and sees that knowledge derives from the active participation of people in the process of transforming their social and natural worlds. In stating this Freire rejects the 'asocial' conception of knowledge acquisition - the notion that disinterested, unmotivated observation is the means by which the world may be apprehended. The knowing Subject, and therefore knowledge itself, cannot be seen to be separate from personal, social and political interests.

Countering the fundamental conservatism of positivistic science Habermas (1972) asserts that knowledge is not separate from interests fundamental to human socio-cultural existence. Habermas therefore, like Freire, clearly rejects the 'asocial' view of knowledge described above and embraces the view that knowledge is embedded in social practice.

Hegemony

Where the first account outlined above (contemplative, asocial knowledge) is accepted there is a tendency for knowledge to be treated as though it were a static, immutable entity, as itself an object. Where this occurs the dominant modes of thought may come to be seen as the only possible modes of thought and may not therefore be open to or subjected to rational criticism. In this way they can come to limit peoples choices for action and so 'knowledge' itself becomes objectifying.

The concept 'hegemony' (Gramsci 1971) explains how treating knowledge in this way may come to serve the interests of dominant groups. Such groups may achieve their own ends

at the expense of others, yet this state of affairs comes to be accepted as right and proper by them and those whose interests are not served.

The starting point of Gramscis' description of hegemony is the traditional dichotomy between 'force and consent', with the supremacy of a social group or class manifesting itself in two different ways: 'domination' (coercion) and 'intellectual and moral leadership'. It is this latter type of supremacy that is encompassed in the notion of hegemony. (Femia 1981)

Here choices for action are limited by internal rather than external constraint, domination occurring through 'consent' not direct coercion. A particular concept of reality, or 'ideology', comes to dominate, shaping both thought and actions in line with the prevailing norms. Such ideologies may be expressed in elaborate, abstract form, for example in philosophy, or in a much simpler form such as 'common sense', the informal philosophy of people in general. (Mouffe 1979)

Dominant ideologies come to structure the consciousness of social actors and in this way to inform all individual and collective action. They are reflected within the institutions of civil society and shape '...the cognitive and affective structures whereby (people) perceive and evaluate problematic social reality.' (Femia 1981: 24) Directly or indirectly the the very nature and scope of knowledge, and the understanding of how people may come to know, is moulded by dominant ideologies and therefore possibilities for understanding and social action are necessarily limited.

Exposing such ideologies to rational criticism (ideology critique), with the purpose of freeing people from their constraints (thereby enhancing their ability to make choices) is one of the main intentions of a critical social science.

Critical social science

Held (1980) notes that critical theory does not form a single unity stating that '...it does not mean the same thing to all adherents.' (p.14) Nevertheless, certain basic ideas are inherent in the notion of critical social science.

The most important common general characteristics found in critical social science are:

1) The recognition of both human agency and structural constraint, that is, the acknowledgement that humans are both agents (they have a capacity to be self-determining, self-reflective and to act rationally) and at the same time may be constrained by ideological forces which shape their understandings and actions. Associated with this is the notion that humans may both structure, and have their understandings and actions structured by, their social worlds. (Fay 1975, McCarthy 1978)

2) An acceptance of the interconnectedness of social theory and social practice. In this, critical theories have both a cognitive content (that is, they are forms of knowledge) and a special standing as guides for human action. (Geuss 1981: 1-2) This special standing is reflected in the third common characteristic:

3) an emancipatory intent. This entails a commitment to securing freedom from historically conditioned repression, domination and ideological constraints on thought and action that limit possibilities for people to make choices consistent with their real interests. (Fay 1975, Carr & Kemmis 1983)

4) Lastly, there is a defence of the possibility of an 'independent moment of criticism'. (Held 1980: 15) Jürgen Habermas grounds this possibility in the conditions of the 'ideal speech situation' (see p.18).

Giroux (1983: 8) notes that critical theory (hence critical social science) is both a school of thought and a process of critique. Thus it is appropriate to see critical theorists as not simply adhering to a particular philosophical position but as actively engaged in a process of critical theorising. The aim of such theorising is to liberate people from the domination of forces which may prevent them from acting rationally and autonomously.

In this concern with emancipation

> ...critical theory (seeks) to penetrate the veil of ideology and to elucidate the mechanisms of repression which characterise a particular social formation.
>
> (Thompson 1981: 95)

Understanding the dynamics of social practice, then, necessarily entails examining the meanings social actors attribute to their actions, and the constraints on those understandings and actions. Thus socially critical approaches seek to locate social understandings and practices historically and subject them to rational critique. This is done with the intention of expanding the possibilities for rational action (choices) of social actors. Critical social theory may therefore be described as '...historically oriented theory with practical intent.' (McCarthy 1978: 220)

The heart of critical social science lies therefore in the critique of appearances. Analysis of the social world is not limited to the examination of 'the given', a simple compilation of empirical 'fact' (as with empirico-analytic approaches), nor to the presentation of the meanings attributed to their worlds by social actors (as with interpretive approaches). It is a dialectical synthesis and extension of both empirical and hermeneutic enquiry. Here there is an attempt to render empirical facts meaningful while '...at the same time placing them in the context of the tension between the given and the possible'. (Schroyer 1978: 251).

In defending the possibility of 'an independent moment of criticism' (Held 1980) critical theorists are claiming that such critiques may be grounded rationally. They claim then that critique may occur unhindered by the very ideological constraints it seeks to identify and overcome. It is in his attempts to provide such a rational grounding that Jürgen Habermas makes a major contribution to critical social science.

Habermas and Critical Theory

Jürgen Habermas has attempted in his writings to recapture and provide the philosophical underpinnings for the initial transformative intent of earlier critical theorists. In doing so he provides the most coherent account (to date) of how critical theorising might occur, and be rationally grounded, in his theory of discourse and rationality. (Jay 1984)

In the introduction to his book 'Knowledge and Human Interests' Habermas writes:

> I am undertaking a historically oriented attempt to reconstruct the prehistory of modern positivism with the systematic intention of analysing the connections between knowledge and human interests.... Retreading this path... may help to recover the forgotten experience of reflection.'
>
> (Habermas 1972: vii)

He identifies three essential human interests and believes that each gives rise to a particular form of science. Empirico-analytic science is seen to arise out of a human interest in technical control. The practical interest in the preservation and expansion of possibilities for action-oriented mutual understanding gives rise to historico-hermeneutic science. Finally, critical social science has as its concern the emancipatory interest of human beings, that is, an interest in:

> ...securing freedom from self-imposed constraints, hypostatised forces and conditions of distorted communication.
>
> (Roderick 1986: 56)

Such freedom is derived in systematic self-reflection, an emancipatory critique revealing systematic distortions in communication and action.

Theory of communicative action

In his theory of communicative action Habermas seeks to overcome the relativism implicit in the views of the Frankfurt School theorists by providing a philosophical basis for emancipatory critique whereby there can be a rational adjudication between possible interpretations.

> The very intelligibility of emancipatory critique - if it is to escape the charge of being arbitrary and relativistic - requires clarification and justification of its normative foundations.
>
> (Bernstein 1985: 17)

This is what Habermas seeks to provide in his attempts to identify and clarify the universal conditions underpinning human communication. In providing this 'quasi-transcendental' argument (Outhwaite 1987) he shows that, in the actual structure of intersubjective communication, emancipatory critique is grounded rationally.

It is Habermas' contention that communicative acts occur against a presupposed background consensus that certain validity claims have been met. These claims are reciprocally, but generally implicitly maintained in each successful communicative act. These claims are:

1) Truth. 'That the statement made is true (or that the existential presuppositions of the propositional content mentioned are in fact satisfied)' (Habermas 1984: 99);

2) Correctness/appropriateness. 'That the speech act is right with respect to the existing normative context (or that the normative context that it is supposed to satisfy is itself legitimate)'(Habermas 1984: 99); and

3) Sincerity. 'That the manifest intention of the speaker is meant as it is expressed.' (Habermas 1984: 99) ie. 'authenticity' (Habermas 1974: 18)

4) A fourth claim identified by Habermas is that of intelligibility ie.'the comprehensibility of the utterance'. (Habermas 1974: 18)

Potentially these validity claims may be rendered problematic in everyday communicative practice. In other words, although each claim is implicitly accepted in all successful speech-acts, in principle each is also open to challenge.

Habermas notes that claims of sincerity can be realised in the process of interaction (ie. the sincere expression of intentions shows itself in actions). Intelligibility may be established in the functioning of language itself ie '...if, and the extent to which, reaching an understanding is attained in a communication.' (Habermas 1974: 18)

The assertions of truth and claims to the correctness or appropriateness of the performative components cannot, however be redeemed in this way, through action and experience. They can, according to Habermas '...only be proven in discourse'. (Habermas 1974: 18)

Discourse

Discourse is, as Bredo & Feinberg (1982: 283) note '...second order communication about communication.' Whereas in everyday communicative action the above validity claims are assumed naively, in discourse all constraints on action are suspended.

Participants in discourse do not seek to exchange information, direct or carry out action, or to have or communicate experiences. Instead they search for arguments or offer justifications in the light of the problematic claims to validity of opinions and norms. This

> ...virtualisation of constraints on action...is intended to render inoperative all motives except solely that of a cooperative readiness to arrive at an understanding....
>
> (Habermas 1974: 18)

Thus, in principle, where other motives are suspended it is assumed that a rational consensus regarding validity claims can be reached given that there is sufficient time to examine all aspects of the situation or proposition discursively. In discourse validity claims are redeemed and decisions arrived at only by the force of argumentation itself.

> ...when the meaning of the problematic validity claim conceptually forces participants to suppose that a rationally motivated agreement could in principle be achieved, whereby the phrase "in principle" expresses the proviso: if only the argumentation could be conducted openly enough and continued long enough.
>
> (Habermas 1984: 42)

Ideal speech situation

As implied in the above statement, discourse as discussed by Habermas presupposes a particular kind of context. This context is what Habermas terms an 'ideal speech situation'. Here participants have equal opportunities to engage in and participate freely in discourse. Each has a symmetrical opportunity to choose and apply speech acts. (Habermas 1984)

This ideal situation, in which equal participation is possible and matters are resolved purely on their merits and not on the basis of any form of coercion or suppression, is seldom even approximated in everyday life. Nevertheless, Habermas believes that this idealised form of communication is:

> ...both presupposed and anticipated in communicative action itself... [Thus] the full rationality of...discourse is itself...dependent upon the extent to which it is conducted under conditions approximating the ideal speech situation.
>
> (Bredo & Feinberg 1982: 284)

Implicit in the notion of reason and rationality itself is autonomy and freedom from constraint.

Systematically distorted communication

Habermas builds on the Marxist notions wherein ideology is regarded as 'false consciousness'. In Habermas' view this notion of ideology finds expression in:

> ...a type of communication that affects the capacity of groups or whole societies to arrive at satisfactory agreements concerning common problems.
>
> (Wuthrow, Hunter, Bergesen & Kurzweil 1984: 223)

Ideology thus ***systematically distorts*** communication. Although participants in communicative acts assume that (or act as though) they have freely arrived at a rational consensus and understood one another, they have in reality failed to do so. The ideal speech situation described above is assumed to have been approximated (or participants act as though it has). However,

> ...because of unacknowledged interests they have engaged only in pseudo-communication, and have failed to achieve a genuine consensus. Preexisting patterns of thought have prevented them from communicating fully or effectively.
>
> (Wuthrow et al. 1984: 224)

The emancipatory interest of critical social science for Habermas is therefore expressed in critique of systematic distortions in communication (ideology critique).

Extant nursing theory

As with critical social science a commitment to the expansion of human potential for understanding and action (choices) is evident in some recently developed nursing theories, particularly those that find their roots in existential philosophy. Paterson and Zderad (1976),

for example, note that people '...become more through (their) choices...'. They see that the aim of nursing is to help people towards

> ...well-being and more-being, the humanistic nursing effort (being) directed towards increasing the possibilities of making responsible choices. (p.17)

Paterson and Zderad also give recognition to the social dimension impinging on the thoughts and actions of both nurses and clients. Implicitly they acknowledge the existence of ideological constraints, that is the 'socially generated illusions' (Held 1980: 41) serving to maintain existing social relations. They write:

> Such choice involves an openness to and awareness of one's own situation. A choice is a response to possibility therefore, one must first recognise that possibilities or alternatives exist. This openness to options is experienced as a freedom to choose as well as a freedom from the bonds of habit and stereotyped response, from routine, from the veils of the obvious. (my emphasis)
>
> (Paterson & Zderad 1976: 17)

They do not however, as socially critical approaches do, provide a coherent account of how individuals' self-understandings may come to be distorted by ideological forces. Growth and choices are supposed to result from nurse guided self-reflection yet Paterson and Zderad provide no basis for examining how such constraints occur nor how they may be recognised and overcome.

Socially critical approaches, on the other hand locate self-understandings historically in order to uncover the processes by which such understandings may become systematically distorted. Such approaches are therefore not simply characterised by an emancipatory intent, they provide a firm basis for critique. The rational grounding of such critique is clearly provided in the work of Jürgen Habermas described above.

Implications for the nature of inquiry

The present study utilises this form of approach to examine the social world of nursing as experienced by four nurses. The explicit commitment to autonomy, freedom and self-realisation inherent in this critical approach is reflected in the research process. This consists of critically reflexive discourse between the investigator and participants, a process

of joint discovery and illumination of social processes and experiences. While as far as possible an ideal speech situation is approximated it is recognised that the research situation potentially brings its own distortions. As Habermas notes: 'The critical vantage-point can never be better than that of a partner in communication.' (Habermas 1982: 312)

Nevertheless, this approach overcomes many of the limitations of methodologies arising out of empirico-analytic and historical-hermeneutic traditions and holds considerable promise for the investigation of the social worlds of nursing.

In the following chapter case study, the methodological approach of this present study, is discussed. In particular, the links between case study and the socially critical perspective described above are explored.

CHAPTER THREE

CASE STUDY APPROACHES

Case study was chosen as the methodological approach of this present study. It was chosen because of its compatibility with the socially critical theoretical stance. In this chapter some of the range of uses of the term 'case study' will be clarified. Sources of the apparent ambiguity and confusion surrounding its use are discussed and areas where these may be resolved identified. Three particular perspectives from which case study may be viewed are discussed, and it is argued that these three perspectives have resulted in three very different uses, and subsequent evaluations of case study approaches.

In recent years there have been numerous references to case study in the literature of a variety of disciplines, generally those most concerned with examining the social interactions of people, for example, anthropology, sociology, and education. This literature also contains numerous examples of case studies undertaken in a variety of settings, for a variety of purposes. Yet, despite its common usage there still appears to be much confusion and ambiguity associated with the term, and much debate and disagreement as to the value of such studies.

Many sources of ambiguity arises out of the apparently diffuse nature of case studies. What actually constitutes a case may vary considerably, for example, from a single person to an entire society. Often the boundaries of the case are problematic and difficult to define. Nevertheless, in case study there is a more or less defined focus of attention and that focus is the 'single case'.

At times case study is treated as a scientific (or pre-scientific method), at times as a grouping of methods. However, while case study is commonly associated with participant observation and interview in the collection of data, these methods do not by themselves define the approach.

Kenny & Grotelueschen (1984) usefully identify a number factors that are commonly associated with case study. They note that:

> ...data are qualitative; data are not manipulated; studies focus on single cases; ambiguity in observation and report is tolerated; multiple perspectives are solicited; holism is advocated; humanism is encouraged; and common and/or non-technical language is used. (p.37-38)

Again these factors provide the general parameters of case study but do not overcome all sources of ambiguity.

While it may be agreed that case study is distinguished by its particular attentional focus (the single case), and that it characteristically draws on particular research methodologies (although may not itself be said to be a particular method or defined by a particular group of methods) there remains considerable disagreement in scientific communities as to the merits of such approaches. It is argued here that much of this disagreement arises out of the tendency to treat case study as a single entity. In particular, there is a failure to acknowledge that differing assumptions about the nature of reality (ontological assumptions), assumptions about the nature of knowledge (epistemological assumptions) and differing views regarding the purposes of social science enquiry give rise to distinctly different types, and consequent evaluations of the value of case study approaches. These differences are so fundamental that it seems appropriate to distinguish at least three different uses of the term 'case study', or 'forms' of case study, each reflecting one of three different traditions of social scientific enquiry - empirico-analytic, historical-hermeneutic and critical traditions.

Empirico-analytic approaches

In the first of these traditions - the empirico-analytic tradition - there is seen to be a single tangible reality that is '...fragmentable into independent variables and processes, any of which can be studied independently of the others...' (Lincoln & Guba 1985: 37) Reality is seen as being comprised of observable events that are related in nomological fashion that is, 'if X then Y under situation C'. (Fay 1975)

The assumption that nature is uniform leads scientists to seek universalistic laws underlying such uniformity, with the ultimate purpose being the prediction and control of events. It is assumed that specific populations can be defined on the basis of particular characteristics,

individual data being collapsed into group data, and that the influence of other variables may be excluded by statistical methods with a view to establishing causal linkages.

Adherents believe that the enquirer (or knower) and the object of enquiry (or known) are separate, and that 'scientific' methods allow 'objective knowledge' to be generated independently of personal values. It is assumed that this is synonymous with 'interest free knowledge'. Habermas in proposing his epistemological theory of cognitive interests challenges the assumption that knowledge may be interest free and sees that the interest of the Empirico-analytic sciences resides in technical control and manipulation. (Habermas 1972) Importantly, however, within this tradition not only is scientific knowledge seen as providing the basis for manipulative control of nature, but what can count as scientific knowledge is seen as being limited to that which

> ...gives us the means by which one can in principle control phenomena. (Thus)...technical control is a defining element in the scientific enterprise itself.
>
> (Fay 1975: 41)

Such ontological and epistemological assumptions have consequences for the way case study is viewed by those working within this tradition and for the use to which they can see it legitimately being put. Its legitimate purpose viewed from such a perspective must necessarily be restricted to pre-scientific enquiry as it, by its nature, fails to meet the evaluative criteria imposed by empirico-analytic science in its attempts to accumulate the only form of scientific knowledge legitimate within this tradition - 'objective' knowledge that, at least in principle, contributes to technical control of phenomena. Such criteria include meeting the traditional standards of reliability, validity and generalisability.

Though failing to meet these criteria for the generation of scientific knowledge case study viewed from this perspective is nevertheless seen as having a pre-scientific value. This value lies in the characteristically 'thick' descriptions of situations and phenomena provided by case studies. Through this, problems for later scientific investigation may be identified, hypotheses generated, and variables isolated.

Historical-hermeneutic approaches

In a second tradition within social science - the historical-hermeneutic tradition - case study is accorded more general acceptance. Here many of the assumptions of empirico-analytic science are challenged and knowledge claims differ.

Empirico-analytic science is based on the notion that there exists a single tangible reality that scientists can, at least in principle, come to know fully through experience with that reality (an ontological position identified by Lincoln & Guba (1985) as 'objective reality'). In contrast, historical-hermeneutic approaches seem to assume a second ontological position described by Lincoln & Guba - that known as 'perceived reality'. Here it is asserted that reality can only be understood by taking account of the vantage point from which it is viewed. It is claimed that there is necessarily an interaction between a tangible reality and the viewpoint of that reality. There can therefore be different interpretations depending on the the viewpoint of the observer (knower), every viewpoint offering only a partial view.

Just as Habermas in his theory of cognitive interests identifies empirico-analytic science with a particular interest, so he also does with historical-hermeneutic science. This time it is seen as a 'practical interest' concerned with the way people understand themselves and others and interpret their actions that underpins the approach.

Whereas the possibility of technical control provides the basis from which scientific knowledge is seen as established, according to the empirico-analytic tradition, it is

> ...the ability to participate in a communicative interaction which defines what is to count as truth in an interpretive (or historical-hermeneutic) social science.
>
> (Fay 1975: 83)

Communication of meaning therefore becomes a defining character of what is to count as truth. Such truth in scientific study is validated by the social actor agreeing with the observer that the correct account of an action has been given.

This view has implications for the way the complexity of social situations is dealt with, and for the place of case study, in scientific investigation. Empirico-analytic science acknowledges that social situations are complex but deals with this aspect by seeking law-like regularities within them, decontextualising as far as possible in order to isolate specific phenomena and causal relationships.

Historical-hermeneutic science on the other hand depends on the understanding of the meanings. Reality is seen as a function of the interaction between the tangible reality and the viewpoint of the observer. To examine phenomena in isolation from their social contexts

is therefore to have little understanding since human experiences are seen as distinct and context bound.

Case studies viewed from this perspective are seen as valuable as sources of scientific knowledge. They enable the researcher to investigate and '...make visible the meaning structures embedded in the lifeworlds which belong to the human expressions under study'. (Van Manen 1976: 215)

Critical approaches

Critical approaches provide a third tradition from which case study may be viewed. Within this tradition many of the assumptions of the historical-hermeneutic tradition are accepted but extended. Again case study gains a general acceptance.

Where Habermas' theory of cognitive interests gives recognition to the 'technical' interests of empirico-analytic science, and to the 'practical' (communicative) interests of the historical hermeneutic sciences, critical approaches are, according to Habermas, characterised by their 'emancipatory' interests. Such emancipation involves the revelation and correction of distorted elements in interaction and communication.

Within this tradition there is an explicit acceptance of knowledge as constituted by interests - neither the technical interests of empirico-analytic science or the practical interests of historical-hermeneutic science are rejected. These are seen as real human interests. What is rejected however are the theories of knowledge that take these interests as fundamental to the constitution if knowledge. (Comstock 1982)

Critical approaches view people as active constructors of their social worlds, and of their knowledge about those worlds. Individuals and social groups are seen as capable of transforming the conditions of their social existence. Social structures are also seen to shape the perceptions and meanings that social actors attribute to their lifeworlds. Such taken-for-granted meanings may be ideological in nature, obscuring or legitimating dominance-subjugation relationships.

The notion that the observer may be separated from the observed, knower from the known, is rejected. The researcher participates in, does not simply report the world 'as it is' (as the empirico-analytic approaches claim to) nor simply as research subjects see it to be (as in the historical-hermeneutic approaches). Here it is acknowledged that the researcher actually participates in the structuring and maintenance of the social world under study.

These views of the world and knowledge lead to a quite different conception of the nature and value of case studies. For empirico-analytic science, interested in technical control, case studies are seen to have a pre-scientific value. And for historical-hermeneutic science with its practical interest in communicating meaning, case studies provide the means by which this may occur. For critical approaches, however case studies become focus points for critical activity or theorising.

Case studies carried out from an historical-hermeneutic perspective are inherently conservative, serving to maintain the situations they describe by providing static representations of dynamic social worlds. Critical social science on the other hand is distinguished by its commitment to emancipatory social action. It seeks to examine interactions between historically preformed structural conditions, human understandings and social action. At the same time, the way in which ideological distortions have masked contradictions between intentions and structural possibilities are explored.
(Comstock 1982)

What is required then is an examination of the contexts in which social actions are situated and a sensitivity to the lived experiences, interpretations and understandings of social actors. Here case studies are valued for their ability to provide opportunity for researchers to take account of such complexity.

Case studies within critical approaches are also valued for their emancipatory potential. They seek to reveal and rectify ideological distortions in the meanings research participants attribute to their social worlds. Case studies, as focus points for critical activity provide research participants with opportunities to emancipate themselves from domination by enabling them to see new possible ways of understanding and acting upon or within their social worlds.

Case study here is reflexive. It involves dialogue between researcher and participants in order to surface unrecognised social constraints and new possibilities for action. Participants and researcher <u>together</u> theorise about the case. There is no clear endpoint to case studies viewed from this perspective. Ongoing engagement in self conscious action is the aim of such studies.

Case study reports themselves provide an ongoing focus for critical activity beyond the immediate research participants. Such reports provide an account and critique of the way in which the social conditions, and subjective understandings of those conditions, develop and are maintained. They identify new possibilities for choice and action. In doing so they potentially illuminate situations beyond the case actually reported.

By providing such analyses the reader is offered a 'surrogate experience' and may begin to engage in critical reflection on the conditions of their own social worlds. There can be no direct application of one account to another situation since each social context, and each persons experience with that context is distinctive. However, the identification of similarities and differences may serve to allow the reader to develop their own understandings and may enhance their potential for action. Again, previously unrecognised social constraints and possible course for action may be surfaced. Case study within critical approaches then is an ongoing activity. There is no clear endpoint. Case study reports are not seen as providing a full and finished account. There is a continuing process involving the evolution of understandings and increasing potential for action.

The value of case studies and the validity of critical theories produced within them are testable only in action. As with historical-hermeneutic approaches, the responses of participants to any claims made in accounts provide the test of their validity. However, as Comstock (1985) points out, the aim of critical approaches is to '...stimulate a self-sustaining process of critical analysis and enlightened action'. (p.387) Enhanced self understanding and political action are an integral part of the research process. It is these which provide the test of the value of each case study.

It is this final form of case study that was the perspective chosen for this present study. Each case therefore became a focus for socially critical reflection and analysis. The actual procedures followed are described in the following chapter.

CHAPTER FOUR

METHODOLOGY

In this chapter the methodological procedures of the study are outlined. Ethical considerations arising out of the chosen methodology, and precautions taken to protect the participants are identified and discussed.

Procedures

a) Participant Selection and Settings

The study was carried out at a large regional New Zealand hospital. Three different types of acute care surgical ward were chosen and, from the list of all the full time staff nurses working rostered shifts in these areas, two names from each area were randomly selected. As a case study approach was to be utilised for the purpose of exploring, in depth with individual nurses, their unique experiences of their practice worlds no attempt was made to obtain a sample representative of any given population.

Potential participants were approached individually in the wards in which they worked and given a brief verbal explanation of the study. An arrangement was made with each nurse for the investigator to make contact by telephone the following day. The purpose of this contact was to confirm a suitable date and time for an individual meeting with each nurse in order to discuss their possible participation in the study. It was emphasised at this time that consent to participate in this first meeting was not consent to participate in the entire study.

At this first meeting, held at either the investigator's or potential participant's house, the purpose of the research, and the nature of the research process were described and discussed. Each nurse was given the opportunity to ask questions and clarify any points made. At the end of this meeting verbal consent to participation in the study was obtained. It was emphasised however that if the nurse so wished she could withdraw from the study at any stage of the research process. In situations such as this verbal consent following full discussion was considered preferable to using a written consent form.

One nurse approached in the ward stated that she would prefer not to be involved in the study. Another staff nurse working in the same ward was subsequently approached and

agreed to participate in a preliminary meeting with the investigator. One person at the time of the preliminary meeting decided not to participate in the study. She stated that she did not feel that she would have the time or commitment required to participate over a period of time. The other five nurses approached agreed to a first interview.

b) Interviews

In-depth, generally unstructured interview, a critically reflexive dialogue between investigator and participant, was chosen as the principle research method because it was seen to be compatible with both the purpose and the theoretical approach of the study. Such dialogue '...presents a potent method of integrating inquiry and intervention... (contributing to) the intermingled process of knowing and changing.' (Tandon 1981: 293).

The interviews provided each nurse with the opportunity to act as a research participant rather than simply being observed as a 'subject' or 'object' of the research process. Each observed her own social world, described and reflected on her own experiences, and joined the investigator in actively interpreting these observations.

After the preliminary explanatory and consent interview four interviews were conducted with each participant over a period of 6 months. A fifth interview was conducted 10 months later. Participants spoke informally with the investigator on the telephone and in the work setting at irregular intervals during the times between interviews.

It was considered that this number and spacing of interviews would provide opportunity for the ongoing process of self-reflection to be observed and any changes to be analysed with the participants. Interviews were undertaken in the informal atmosphere of the home of either the participant or the investigator depending on the preference of the participant.

Interviews lasted from one and a half hours to three hours and between forty-five minutes and a hundred and ten minutes of tape-recorded material was obtained from each of these. Several hours of informal conversation between the participants and the investigator were not recorded.

All interviews after the preliminary one were recorded on audio-tape. This allowed comments to be placed more accurately in context during analysis and further meaning to be obtained through access to inflection, tone of voice etc. Transcription of the tapes also

allowed participants to check the accuracy of recorded comments and the investigator to follow up at subsequent interviews points that required further clarification. Participants were informed that they could request that the tape-recorder be switched off at any time and that segments of recorded material be deleted if they so wished. None of the participants chose to exercise this option.

Interviews, although largely unstructured, were focussed upon each nurse's experience of her practice world. Each interview therefore began with a general question asking the participant to tell the investigator about any significant events, experiences or thoughts that may have occurred since the previous interview.

Between interviews each participant was asked to write down in an exercise book any thoughts that she may have arising out of or relating to previous discussion or to events in the practice setting which they saw as significant in any way. This was intended to facilitate a continuing reflective process and provide a direct link between the interviews and the experienced practice world. Notes made by the participants formed the basis for discussion during the next interview, but other than this were not formally analysed by the investigator.

After each interview the tape-recordings were transcribed and preliminary analysis of this material was undertaken by the investigator. Particular points to follow up at the next interview were identified and tentative interpretations made. These were discussed with the participants at the next interview.

During the fifth interview with each participant a draft of the thesis chapter interpreting this person's experiences was discussed with them and they were provided with the opportunity to challenge or clarify interpretations and/or request that information be deleted. The participant's impressions of the total research process and its effects were also explored.

One participant chose to withdraw after the first formal interview. She stated that this was because of personal commitments (outside the work setting) which meant that she did not have time to continue with her participation. Although she gave permission for material already collected to be used in the study this was not considered to be compatible with the methodology and theoretical approach of the study. The tape recording and transcript of the interview were therefore destroyed.

c) Documentation

While the major focus of the study was on the meanings and interpretations of the nurse participants it was thought that a brief analysis of nursing documentation would contribute to the exploration and critical analysis of knowledge and its transmission in the three chosen settings. To this end, over a period of three months, the charts of 28 patients (10 each from two of the ward areas and 8 from the other) were examined. Data collection focussed particularly on documentation of patient education/information needs and of nursing interventions in relation to these. The results of this analysis of documentation were used as one focus point in the discussions with participants.

Ethical Considerations

In this study the following procedures were undertaken in order to provide the conditions in which ethical standards were maintained. Before the study commenced the research proposal was presented to and discussed with members of the Massey University Human Ethics Committee. The proposal was then forwarded to, and approved by, the Principal Nurse and Ethics Committee of the hospital at which the study was to be undertaken. The investigator also met individually with the Assistant Principal Nurse and the Charge Nurses of the three chosen wards to explain the study in detail and gain their approval.

Inherent in the critical theory framework guiding this study is an explicit ethical stance. This affirms the rights of individual human beings to be autonomous and self-determining. In research carried out with human beings the investigator is therefore under an obligation to ensure that these human capacities are not placed under threat. As such, investigators must ensure that potential participants as far as possible are informed of, and understand the implications of consenting to participate in the research and are in a position to freely choose whether or not they wish to do so.

Enhancing these capacities of self-determination and autonomy is an explicit goal of research carried out with a critical theory perspective. Providing the conditions for socially critical self-reflection through which participants may come to view their social worlds differently and see alternative choices for action is built into the research process. Research guided by a critical theory perspective is also then openly interventionist. This places a further burden on the investigator to ensure that as far as possible the participants understand the nature and anticipated effects of this type of research and are therefore in a position where they can freely choose whether or not they wish to participate.

Before consenting to a preliminary meeting with the investigator potential participants were given a brief explanation of the study and its purposes. An extended informal meeting was then held with each potential participant in order to establish that they understood as far as possible the purpose, nature and anticipated consequences of the research. Participants were informed that they could choose:

a) not to participate, or
b) to withdraw from the study at any time, with no adverse effects on themselves, the investigator or the research itself.

Confidentiality was maintained in the study by the use of pseudonyms and exclusion of all data that may potentially identify the participants. Minor alterations of participant details, in ways that would not significantly alter the ability of readers to place interpretations in context, were also made.

Preserving individual's rights to autonomy and self-determination was also a concern in relation to the examination of nursing documentation. All nurses working in the areas in which these data were to be collected were given a brief written explanation of the purpose and procedures of this part of the study (refer appendix). They were invited to ask questions of the investigator if further information was required.

Permission to view the documentation related to any individual patient was obtained by the investigator in a short interview with the patient concerned prior to any examination of the particular file. Patients were informed that the focus of the study was on the type of information collected by the nurse, and the way that this was documented, not on information relating to the particular case. It was emphasised that they could refuse to allow their notes to be viewed with no fear of repercussions, and that confidentiality would be maintained.

The express goal of enhancing human capacities for self-determination and autonomy places additional obligations on investigators to not only share information at the beginning of the research but also to share the process of analysis and research results with the participants. In this study much of the analysis was undertaken in the actual process of dialogue with participants. Accuracy of transcriptions and of any interpretations made by the investigator were checked out and explored with participants.

During the fifth interview draft case study material was shared and discussed. This provided participants with an opportunity to check that no material by which they could potentially be identified was included, a further opportunity to comment on the accuracy of interpretations, and a chance to discuss the total research process. The completed thesis will also be viewed by, and discussed with, each participant. These opportunities are seen to be particularly important given that reflection may continue well beyond the somewhat artificially imposed boundaries of the study.

PART TWO

PART TWO

THEORETICAL COMMENTARY
KNOWLEDGE, ACTION, AND THE PRACTICE SETTING

In the following four chapters the interview data of each of the four participants is analysed individually with reference to the theoretical and methodological stance described in chapters two and three.

Each chapter has a brief summary section and an extended commentary section. Each begins with a summary of the theoretical analysis and material is referenced to the appropriate sections of the full commentary which follows.

In the full commentary the participants' views of knowledge and their experiences and understandings of practice and their practice settings, are analysed. This analysis is illustrated by excerpts from the participant interviews.

Concluding each chapter is comment and analysis arising from the final formal interviews (conducted ten months after the fourth interviews). At these interviews a draft of the chapter providing the theoretical analysis of the previous interviews with each participant had been discussed with her and opportunity for comment provided.

Following on from the analysis of the case studies Part three explores the participants' shared understandings of personal and professional experiences of nursing in acute care settings.

In order to facilitate the readers task the following conventions have been used in presenting the data and accompanying commentary.

Key to transcripts

[ ]	Interviewer questions/comments during interview.
Italics	Participant answers/comments.
...	Pause.
(...)	Material edited out.
< >	Background information
Numbers	
(eg.E1/2/3)	Participant,interview/page/paragraph.
Plain type	Commentary

CHAPTER FIVE

'AMY'

PROFILE

Amy is a Registered Comprehensive nurse in her early twenties who completed her basic education at a technical institute several months prior to the first interview. Some of the clinical experience completed by Amy during the basic course had been undertaken at the hospital where she was working at the time of the interviews.

At the time of the first interview Amy had been working in her first ward as a staff nurse for several months. The area she was working in was an acute care surgical ward. Prior to the fourth interview she transferred to another acute care surgical ward.

SYNOPSIS

The interviews with Amy provide clear evidence of contradiction between her personal knowledge and beliefs, her professional knowledge and beliefs, and the intersubjectively held beliefs of institutional members that shape, and are communicated in, institutional practices.

For example, in her early interviews Amy provides clear evidence that she accepts as legitimate and unchallengable the existing relationships within the social setting in which she works, hierarchical relationships in which doctors in particular are seen to have legitimate authority over other staff. Amy shares with other social actors the belief that this authority is derived in the knowledge base which doctors are assumed, by virtue of their position, to possess.

Amy knows from her own experiences however, that some doctors to whom she and other nurses automatically accord authority do not actually possess the knowledge on which this authority is seen to rest. Yet, although she states that she does not respect some individual doctors because of this recognised knowledge deficit, she does continue to acknowledge their authority even when she clearly believes that this is not in the patients' best interests, and may even be dangerous. (pp.40-43)

Amys' acceptance of the legitimacy of the authority of doctors is also evident in the way in which she interacts with medical staff. In particular she accepts that she must orientate her own behaviour towards the expectations of doctors - she treats them with caution until she has determined the level at which they wish to interact. Amy accepts that at times doctors, for example, '***get really rude***'. She is therefore hesitant in her interactions with doctors until she knows how they will react. It is clear that this hesitancy at times inhibits the ability of Amy and other nurses to act. (pp.43-46)

Amy provides a personal explanation for the above situation ('***I get really easily intimidated***'). Despite this she is able to briefly reflect on the ways in which she and other nurses actually participate in maintaining the status quo. This penetration of the intersubjectively held beliefs that effectively constrain her actions is, however, only partial and she reverts to personal explanations for the constraints which she experiences. Hence, existing relationships continue to be seen as natural and unchallengable. (pp.46-47)

Social relationships within the institution are also seen by Amy to constrain the ability of patients to act. In particular institutional practices such as doctors' rounds may produce and reproduce a vulnerability which she sees that patients exhibit, and may prevent them from obtaining, or conveying information which is relevant to their situation. People, she notes, '***look on doctors as gods...***'. (pp.47-48)

Amy attempts to support patients in overcoming this vulnerability by:

a) encouraging them to be '***assertive***'and

b) acting as an intermediary between doctors and patients.

(pp.49-50)

The first of these actions, encouraging assertiveness, seems contradictory in that she acknowledges that she herself has difficulty in interacting freely with those seen to be in authority, particularly doctors. The second, conveying information from patients to doctors and vice versa, does little to challenge existing relationships and practices and may actually serve to perpetuate them.

Amy explains that doctors have difficulty conveying information to patients because they (doctors) know 'too much' and therefore cannot use language that patients would

understand. She does not acknowledge that it is her own knowledge base that allows her to interact at an appropriate level with patients. Her actions are therefore not valued as knowledge-based and to a large extent remain invisible. (p.50)

Thus, Amy sees that contributing to the difficulties that patients may have in obtaining or conveying information are:

a) the social relationships in which patients are often overawed by doctors,

b) social practices which reflect, produce and reproduce such relationships, and

c) the amount of knowledge which doctors are seen to possess.

These constraints are clearly accepted by Amy as 'natural' and essentially unchallengable. Any divergence from the pattern of interaction between doctor and patient is seen to be an exception - an individual difference. (pp.51-52)

Although Amy accepts that it is important for nurses to intervene on behalf of patients and participate in redressing knowledge deficits (by interpreting and filling in gaps) she also reports that nurses are at times limited in the extent that they can do this because they themselves do not have access to particular kinds of relevant information. This is because doctors are seen to have legitimate control over certain kinds of information. Amy therefore knows that she must at times be cautious in her interactions with patients for fear of encroaching on areas that are considered '***a no-no***' as far as the doctor is concerned.

Amy notes that such information generally involves a diagnosis that may come '***as a shock to the patient***'. She knows that in such circumstances, once the patient has the information, she as a nurse should be available to help them with their emotional response. Yet, she herself is sometimes unaware just how much of this type of information the patient actually has been given. Consequently, while she knows she should be available to help the patient she must at the same time be careful not to give anything away. This uncertainty constrains the type of interaction that can occur between the nurse and the patient.

(pp.52-55)

A final example of contradiction between different levels of values and beliefs (some expressed and perpetuated in social practices, others denied expression) can be seen in Amy's descriptions and explanations of the frustration she experiences when she cannot provide the standard of care that she believes, as a professional nurse, she should be

providing. Although frustrated, Amy feels powerless for she believes she cannot alter the circumstances that lead to this frustration. She sees time pressure as a 'natural' and unavoidable part of the practice setting. Some aspects of nursing care that she acknowledges are important therefore come to be seen as '***a little bonus***' rather than an integral part of her nursing practice. Knowledge which underpins professional nursing practice may therefore not be expressed in nursing action as she provides '***just the bare essentials***'.(pp.55-57)

EXTENDED COMMENTARY AND INTERVIEW DATA

Knowledge and authority

One characteristic of bureaucratic organisations is the generally clearly distinguishable lines of authority by which (at least officially) decisions are made. While such authority is often achieved and assumed by virtue of the position which a person reaches in the organisation there are often particular beliefs shared by social actors about the origin of this authority. These beliefs serve to legitimate what may otherwise be seen as arbitrary decisions about, for example, who should be in charge.

One factor that may be seen as the legitimate basis for authority is the perceived knowledge base of those who are accorded or assume such authority. Linking authority with perceived knowledge in this way potentially influences the types of actions expected of those seen to be in authority, the actions of other institutional members and the types of interactions that occur between them. One effect is that social actors may automatically defer to the decisions of the authority figure because of the shared belief that knowledge and authority are linked in this way.

Amy, for example, believes that doctors legitimately have authority over herself and other nurses within the work setting. She associates this authority with the type and amount of knowledge that she believes that doctors should, by virtue of their position, possess. However, Amy is aware that some doctors to whom she and others automatically accord authority do not, in her experience, actually possess the knowledge on which this authority is assumed to rest. She notes that she therefore does not '***respect***' these particular doctors. She does, however, continue to acknowledge their authority. This is illustrated in the following excerpt from interview 2.

A2/27/1
I don't look up to the house surgeons as much <as she looks up to the registrar and consultant>*... I respect them and hope that they respect us... I think it's mainly because they're younger and they're still training themselves and they'll often ask you "What do you want this person to have?" or something, rather than tell you, so...*
[Do you like that?]
It depends why. Sometimes it's cos the doctor wouldn't have a clue - if it's a medical intern often it's quite amazing. They often don't know that much. It makes you wonder how much they know. It depends in what way they ask you really. Like we had on we person who was having Dilantin infusions. (...) me and another staff nurse looked at it and thought "Gee, that's a high dose". I think they were having three hundred three times a day... a really high dose, and we thought it was pretty amazing so we rang the medical intern working for them and she says "Well, I don't know". We sort of thought "Well, we'll give it to you to decide but we're not happy giving that much"... but I mean, when a doctor says "I don't know" in a really dumb way I mean you don't trust them much.(...) she actually looked in the New Ethicals with us and the maximum was three hundred daily (...) they'd been given it but I don't know who prescribed it but it wasn't our problem anyway. I didn't want to get involved in it. I thought well, we'd given it but I mean it wasn't really our responsibility so... (...) well, yeah, it was our responsibility cos we should be aware of the dosages that are given but, like, I don't think it really lay on us. It was the person that prescribed it but I don't think anything came out of it. I mean the patient was totally O.K.(...) I came on a few days later and they'd finally changed it (...) That really was just one circumstance where I didn't sort of really look up to a housesurgeon.

Amy clearly indicates that she expects doctors to have the knowledge which would allow them to make effective decisions in situations such as that described above. A 'good' doctor worthy of her respect would certainly have this knowledge.

This expectation reflects beliefs that Amy shares with others within the work setting:

i) belief in the legitimacy of the authority of doctors over nurses and others within the work setting and
ii) belief that this authority finds its origin in the knowledge that doctors possess <u>because</u> they are doctors.

Amy, however, has personal knowledge, derived from experiences such as that above, that contradicts these beliefs. She knows that '***...sometimes the doctor wouldn't have a clue (...) they often don't know that much***'. That Amy describes this as '***amazing***' is hardly surprising. After all, the beliefs which this knowledge contradicts are the beliefs shared with others - the taken-for-granted 'conventional wisdom' which justifies the existing social order and structures of the setting in which she works.

Although in the above extract Amy is faced with evidence that contradicts this 'conventional wisdom' she does not recognise it as seriously challenged. Indeed, she uses these beliefs as justification for actions which she clearly understands were not in the patients' best interests. Thus, while she claims she does not respect the doctor she does, as her actions and explanations indicate, continue to respect his authority.

Amy therefore gives a dose of Dilantin that she obviously believes is excessive because it has been prescribed by one doctor and another doctor (a medical intern who she knows does not have knowledge that would allow him to make a reasoned decision) does not overrule this prescription. She explains that, while it was the nurses' responsibility to be aware of the correct dosages of the drug, beyond this '***...I don't think it really lay on us***'. She places the ultimate responsibility on the prescriber of the drug whose authority she questions only to the extent of consulting another doctor (even though she does not respect this other doctor because of his apparent lack of knowledge.)

Amy resists a clear challenge to the 'conventional wisdom' and does not see it is her responsibility, or indeed an option, for her to have challenged the doctors' authority in this situation. Her explanation of what occurred remains at the level of the individual in that she sees that it is just this <u>particular</u> doctor who does not have the knowledge expected of him. She does not question the automatic assumption that doctors are, by virtue of being doctors, in a position to make decisions and take responsibility for them in such situations; nor does she question the structures wherein a doctor, who she acknowledges appears to have limited relevant knowledge, is placed in a situation where he must make such decisions.

Her actions continue to be constrained by the belief that the authority of doctors is justified because they have knowledge, and this authority cannot be challenged even when it is clear

that this assumption is unfounded. In respecting the authority of the doctor Amy denies that her own personal and professional knowledge is relevant to the situation. Thus, in conforming to the expectations deriving from conventional wisdom, she separates her personal and professional knowledge from her actions.

The intersubjectively held, unexamined beliefs described above are both transmitted by, and constitutive of, the wider institutional structures. They can therefore be seen to be expressed in a variety of institutional practices and relationships.

Patterns of interaction

One way in which these beliefs can be seen to be expressed is in the patterns of interaction between social actors in the work setting. Amy, for example, recognises that she does not relate to doctors in the same way as she does to other nurses. Nor does she relate to all categories of doctor in exactly the same way. This is illustrated in the following extracts where Amy talks about her relationships with the various categories of doctor.

> A2/29/1
> <Registrars have> ***got more authority*** <than housesurgeons>.(...) ***obviously a registrar's higher up the scale than a house surgeon and a consultant's even higher. I think you look at it a lot like that and you don't see the registrar that much and you wouldn't call him for nothing. You respect the fact that he might be busy or he might be in surgery and he's got other things to do... so you wouldn't call him unless you really had to and in that way I think you look up to him.***

> A2/26/2
> [Do you relate differently to the consultants than you would to the house surgeons?]
> ***Yeah I do. Some people say you shouldn't, they're still just humans, but you tend to look up to them and you can't help it.***

Amy is acutely aware of the dominance of medical professionals over others, including nurses, within the work setting. She also clearly identifies the strictly hierarchical organisation within the medical practitioner group.

While she is aware that it is, at one level, possible to see that consultants are '***still just human***' she herself looks up to them and feels that she cannot do otherwise, after all, '***you***

can't help it.' Thus she implies that it is so 'natural' for nurses to look up to consultants that there is no way that she, or presumably other nurses, could hope to view it in any other way. Registrars, are obviously higher up the scale than house surgeons but lower than consultants. Amy again sees that it is natural for her to look up to them and to orientate her own actions so as not to bother them unnecessarily.

This dominance of medical practitioners over nurses is also reflected in the way that they are seen as legitimately able to control the the patterns of interaction between doctors and nurses. Thus Amy treats doctors with caution until she has determined how they wish to be treated or how they are likely to treat her. This is illustrated in the following extracts from interview 3. In the first of these Amy is discussing her experiences of interacting with registrars.

> A3/21/2
> ***It really comes down to the type of person they are, how easy are they to communicate with... and I guess what they think of themselves as a registrar. Some of them I think it really goes to their head and when it goes to their head we tend to treat them... you know, they might think they're God... so they act that way. Like they wouldn't just come up and say "Hi, how are you?", call you by your first name or... they might just call you "nurse" or something.... That's why I say I think you tend to, even if it's subconsciously, you tend to treat them more as they want to be... If a doctor calls you*** <by your first name> ***and talks to you just on a human kind of basis you'll tend to respond in the same way... but if they don't, well you don't sort of get chatting with them and they obviously don't want to.***

It is clear that Amy believes it is necessary for her to orient her own behaviour towards the expectations of the doctor. She explains that the way she '***responds***' to the doctor depends on what type of person she sees him to be. Thus Amy simply applies an individual explanation to what may also be analysed in terms of wider intersubjectively held beliefs. Not only are doctors' perceived to have legitimate authority, but their dominance extends to a legitimate control over both the type and the level of interaction that can occur between the doctor and the nurse.

Amy therefore feels that she must treat doctors as they wish to be treated; individual doctors can act as though '***they're God***' and nurses will orientate their behaviour to accommodate this; they can talk to nurses not '***on a human kind of basis***' and this will be accepted; they

can choose whether or not they will call the nurse by her first name, and this will alter her perception of the way in which she can interact with him. The doctor acts, the nurse conforms to what is expected of her.

Similar dominance and control is reflected in the following extract from interview 3.

> A3/29/4
> ***I notice the*** <nursing> ***students are obviously... often hesitant to help*** <doctors with procedures> ***because they're scared they'll do something wrong but I find now... I mean we're all human, we all make mistakes and it doesn't matter if you're going to do something wrong. (...) you tend to just do your best to do what you think he wants you to do.(...) I've heard some of them can get really rude to you. I think that's why you play it a bit cool... you don't want to put your foot in it, because some do (...) get really rude to you. I've never had it myself but I know some people have and have been totally put off doctors for life.***

Amy recognises that student nurses often prefer not to assist doctors with procedures because they are '***scared they'll do something wrong.***' She herself claims to have accepted that, as a human being, she will inevitably make mistakes and can only do her best. Despite this claim Amy orientates her activity towards pleasing the doctor and is constrained by the expectation that doctors can, and do '***get really rude to you***' when you '***put your foot in it***.'

Although Amy states that she herself has never experienced such rudeness on the part of a doctor her ability to act is never-the-less clearly restricted by the expectation that this could occur. Because she expects that doctors can be rude when nurses do not do precisely what is expected of them, Amy sees that they have to '***play it a bit cool***' until they know what the doctor wants of them and how the doctor will act towards them.

Nurses it seems are often in a state of uncertainty. They know that they are expected to anticipate the doctors' wishes yet they also know that doctors can be (and are allowed to be) unpredictable in their expectations and behaviours. Thus, the shared belief in the legitimacy of doctors' authority over nurses, and the associated high value placed on pleasing the doctor, find expression in doctor-nurse interactions that serve to limit the ways in which nurses can act. Indeed, instead of acting nurses can be seen to react in the ways that they believe conform to the expectations of others. Again - doctors are able to act.

Nurses are expected to conform.

Amy goes on to provide a personal explanation for the above constraints. She states:

> E3/30/2
> ***(...) I get really easily intimidated... I know from other situations it would probably have the same effect on me, I'd get a bit upset and feel really bad about it but it's never happened.***

She is never-the-less able to recognise and briefly reflect on the the ways in which nurses actually participate in maintaining the status quo.

> E3/30/4
> [My observation is that there's a tendency for nurses to sit back and take that kind of thing.] <doctors being rude to them>.
> ***Yes. I agree with that. (...) They don't take any action. They just sort of mumble and grumble and leave it at that. (...) and say how unfair it is and that but... just accept it. (...) We sort of let them continue to behave in that way... and they'll continue to be rude to us.***

Amy clearly sees that while nurses continue to 'accept' doctors behaving badly towards them this behaviour is likely to continue. In that she is able to recognise that there are possibilities for action beyond the simple acceptance of this behaviour Amy has partially penetrated the shared beliefs in the 'naturalness' (hence unchallengability) of these relationships.

Despite the fact that Amy has been able to express some understanding that takes her beyond these shared beliefs that effectively constrain her actions (in so far as she is able to see that there are other responses possible other than simply accepting doctors' behaviour) Amy again, in the following extract, reverts to a personal explanation that effectively serves to mask the ideological nature of these beliefs. Existing relationships continue, it seems, to be seen as the unchallengable, natural state of affairs.

> E3/31/2
> ***(...) It's only a handful though, see, in the whole place... it's just that they're loud... and then you hear all about them (...) <if> the doctor has got a name for being a bit abrupt and another nurse is aware they might say to you "Look... don't worry if he's abrupt to you because he's... don't take it personally".(...) It makes you think "Oh no." ...make sure I do everything right... You just don't want to put your foot in it at all.***

Thus she explains that she knows that it is only a few doctors who are actually rude or abrupt to nurses. This personal knowledge, derived from her own experiences and from the shared experiences of other nurses, serves however to mask the effects of the shared acceptance of the notion that all doctors can, if they so wish, behave in this way.

Communicating information

Early on during the first interview Amy made it clear that she was aware that the ability of patients to obtain information and/or convey information to institutional members (in particular medical staff) may be compromised by the social relationships within the institution. During the first interview she comments:

> A1/3/2
> ***... a lot of patients I guess feel vulnerable in a patient role and they won't speak up.(...) usually they never ask, they'll just do it cos "you're the nurse and I'm the patient" and they'll just do it...***

This vulnerability is evident in a variety of situations described by Amy. For example, she notes that, when patients are asked to sign the 'consent for treatment' forms, they:

> A1/14/3
> ***(...) think they're signing their life away even if you do go through it well and thoroughly.***

Later in the same interview she notes:

> A1/20/1
> ***(...)the older*** <doctors, consultants and some registrars> ***they just don't seem to be very beneficial to the patient as far as talking to them and I think partly that's why people look on doctors as gods or something.***

Many social practices within the institution serve to reinforce and perpetuate the vulnerability of patients and consequently their inability to obtain or convey information. For example, during the second interview Amy describes the doctors' rounds.

> A2/20/3
> ***...I tell them to use the doctors' round as an opportunity to ask*** <the doctor questions>***... we usually encourage the patients to ask the doctors cos often they don't ask***

> ***questions.(...) often they either forget to ask*** <the doctor> ***or the whole thing's just so overwhelming that they sort of ask them but don't ask in the way they want... they might miss out something and if I'm there and I know what they're actually trying to find out well it'd be better.***
> [Why is it so overwhelming for the patients?]
> ***Look, there's all these doctors... like it's the team (...) we've got four consultants and they've got their registrars with them and their housesurgeons and the physios, occupational therapists, charge nurse, and possibly a staff nurse, so there's so many people and they all come round and often it's a bit much. The doctors are all talking amongst themselves and the patient doesn't really know quite what's going on.***

Amy is also aware that the doctors who are seen to be the most knowledgeable, and who are consequently believed to be most responsible for the overall care of patients (consultants, and to a lesser extent registrars), in reality visit patients relatively infrequently. Amy is only hesitantly critical of this 'fact' of the practice setting even though it does potentially contribute to the difficulties patients have in obtaining and conveying information. She notes:

> A2/26/1
> ***I think they*** <consultants> ***could give a wee bit more time to the patients and even us really. We hardly see them.***

Elsewhere she identifies the organisational structure as a problem in that the doctor who supposedly knows the patients individual case is often not available to provide information for patients. For example:

> A2/22/1
> ***We give the explanation*** <for pre-surgical patients prior to the signing of the consent form>. ***I feel personally that it should be the clinician*** <doctor> ***that gives the explanation, not us, but it's us. We usually give it.(...)***
> [Why is it the nurses who do it not the clinician?]
> ***Probably just circumstantial really. (...) the house surgeons do most of the ward work. It's not that often that you get a doctor in that's actually the case doctor for that patient.***

Amy apparently accepts the organisational structure that leads to this state of affairs as natural and unavoidable or, as she puts it, '***just circumstantial***'.

Early in Interview 1 Amy described how she attempts to overcome the vulnerability of patients by encouraging them to be more '***assertive***'.

> A1/3/2
> ***I really encourage them to be assertive - I usually just reinforce the fact that we are a team and if they do have questions they've got to ask questions.***

The way that Amy encourages assertiveness was further explored during the third interview.

> A3/23/4
> ***(...) I tend to try and encourage patients to speak up for themselves (...) I would actually sit down with them and say to them "Don't be afraid to speak up" (...) in relation to doctors and that I'll just say to them like... "He's not God"... and often I'd say to them "I'm sure he'd want to know things... they don't know unless you tell them."***

Although Amy encourages patients to be more assertive in asking questions of doctors and providing them with information she also makes it clear that she herself sometimes has difficulty interacting freely with doctors.

> A1/20/2
> [Do you find it difficult to talk to them <doctors> too, or is it just the patients?]
> ***Some of them (...) I keep my distance sometimes.***

Amys' acceptance of the dominance of doctors over nurses was also evident in Amys' descriptions of the patterns of interaction between institutional members earlier in this chapter (see pp.43-47)

In addition to encouraging patients to ask questions (a strategy which she indicates is often unsuccessful), Amy is aware that she often acts as an intermediary between doctor and patient in the transmission of information. For example, she often asks questions on behalf of particular patients because they are not able to ask for themselves.

> A3/17/1
> ***(...) just before a doctors' round (...) we ask them anything that we wanted to know, like the patient wants to know, you sort of work as an advocate a bit, like, the other day a man wanted to go to*** <another hospital> ***and I mentioned it to the doctor for him.***

[Would he not have been able to <ask>?]
Well, he said he would but he never did. Every time the doctors came around and I wasn't there (...) he never asked the doctor so we sort of went with him to try and get him moved (...) <the rounds> ***are (sometimes) difficult. I think they're a bit intimidating in a way. There's sort of these men all round the bed and they're talking away there...***

This type of approach, rather than challenging relationships and practices that discourage patients from obtaining or conveying information, actually supports and perpetuates existing relations of power and practices.

Amy is aware that she also assists in transmitting information from the doctor to the patient. For example, she often translates and fills in gaps for patients after the doctor has spoken to them.

A1/4/6
Often after a doctors' round I'll try and suss out "What has the doctor told you?" or "What have you perceived that the doctor's told you? Often they'll tell them but the patient doesn't understand. (...) if I have been on the doctors' round and that doctor has told the patient <something> ***I'll go back later and fill in the gaps or put it in their language.***

Amy knows that patients often do not understand what doctors have told them. She also believes that in many respects nurses are better able to pass on information to patients than doctors are.

A2/22/5
<Doctors should be> ***quite capable of giving an explanation*** <to the patient> ***(...) but I don't think they really are because they're so knowledgeable that the information they give probably wouldn't be at such a level that the patient would understand.*** <They know> ***too much. (...) explanations that we*** <nurses> ***give the patient understands more (...) we end up just sort of interpreting what they've said anyway...***

Amy explains that the doctors have difficulty providing information for patients because they know '***too much***'. She does not explain that she as a nurse knows more about interacting appropriately with patients in such situations. Thus, the abilities of nurses in relation to the provision of information to patients are not recognised or valued as being knowledge-based. Hence the actions of nurses are undervalued and, in many respects, remain invisible.

It is clear from the above extracts that Amy recognises that patients at times have difficulty in obtaining information which they desire, which they have a right to have and which may be of benefit to them. She also indicates that they may have difficulty conveying information that may be relevant to their situation. As described above, contributing to these difficulties is:

a) the relationships that she sees exists between doctors and patients (she sees that patients, like nurses, are at times overawed by doctors, particularly consultants),

b) the social practices which reflect and reinforce these relationships (for example, the fact that consultants visit patients infrequently and when they do visit their rounds can be be overwhelming for patients) and

c) the amount of knowledge which doctors are seen to possess which is believed to detract from their ability to communicate with patients on a level which patients will understand.

Amy accepts these constraints as being 'natural' and unchallengable. Any divergence from the above patterns is seen to be a surprising individual difference. This is clearly illustrated in the following extracts in which Amy describes the behaviour of one consultant who acts differently towards patients yet is seen as an unusual exception.

A4/12/7
(...) he's a really excellent bloke, he'll come and sit with the patient and really talk on their level and very rarely does he go away and people not really know what's what, and you often find patients really like him because of that, they feel as if they're quite significant, he's got time for them.

According to Amy this sort of behaviour is ***'sort of the exception'***. She notes:

A4/13/2
I think the general public know that most consultants flit in and out and really don't talk to you that humanely, they just sort of talk so much above your head....

Thus, although Amy recognises that it is possible for individual doctors to behave differently towards patients (acting in a way that would overcome many of the above constraints), she does not expect that this can be the usual way of things. To expect this would be to challenge the intersubjective beliefs which Amy shares with other institutional members - beliefs in the natural and legitimate authority and dominance of the medical profession.

Control of information

Another way in which the beliefs which Amy shares with other social actors find their expression is in various ways doctors can be seen to legitimately control certain types of information within the work setting. This results in variable access to information on the part of other social actors within the institution. It also, at times detracts from the ability of nurses to interact freely and openly with patients.

As noted above, Amy sees that it is important for nurses to fill in gaps and act as interpreters for patients in relation to the information provided by doctors. Yet she is also aware that doctors, not nurses control certain types of information. Indeed, Amy notes that she and other nurses may not have ready access to some important information that is relevant to the care of particular patients. Alternatively, nurses may have access to such information but at the same time feel that they do not have the authority to divulge it, even when patients question them directly. These difficulties are described in the following extracts.

A1/4/3

I read through their notes and they've got query Ca secondaries or (...) so you want to know how much they... often I try to sort of suss out whether they... how much the doctors told them. Often the doctors haven't told them a thing and that's very often, it's not a rarity... that happens a lot and it's also difficult for us to tell them because we don't know how much we're meant to tell them you see, so often it's tricky. (...) it's quite a conflict because... so often I think the patient should know but you just don't tell them because that's just not the done thing or you'll wait for the doctor to tell them... I mean the doctor's the person responsible for it.

Amy reports feeling uncomfortable getting patients to sign their consent forms because:

A1/15/1
... you <often> *really don't know what they're likely to have done (...)* <or you wonder> *"How much does the patient know?" You're in the middle of it I tell you (...) and it's tricky finding out what they do know cos you don't want to even suggest... you don't want to even touch on some things just in case it's the big no-no as far as the doctor goes. You've just got a bit of conflict there.*

Clearly certain types of information are considered to be the legitimate preserve of the doctor and nurses must tread carefully in their interactions with patients for fear of encroaching on areas that are considered *'a no-no'* as far as the doctor is concerned. Just what this *'no-no'* information might be was explored during interview 2.

A2/17/8
When I say that it's no-no <information> *that would only be in the circumstance that maybe it's a diagnosis that is obviously going to come as a shock to the patient and I don't really feel that it is my responsibility to tell the patient (...) and it's often difficult to know how much the patient knows cos it's not actually documented.*

While it is clear that nurses must be careful as to what they say to patients for fear of giving information that doctors should be giving, once a doctor has actually told the patient, for example, their prognosis, it is legitimate, indeed necessary, for the nurse to handle the patients emotional response to the impact of that information. However, it is clear in the following extract that Amy at times has difficulty knowing exactly what the patient has been told.

A1/15/4
(...) on a doctors' notes it never sort of says if the patient is aware <of their diagnosis> (...) <Some house surgeons> *are very obliging and you can talk to them and find out* <if they> *know what the person's been told or what the prognosis is (...) others you wouldn't even bother asking them because you know they'd probably say "Oh, I don't know." And sometimes the house surgeons aren't the best ones to approach about something like that. Sometimes the registrar or someone who knows more about the specific case and that condition is a much better person to approach. They're not always able to be approached* <though>. *They're very busy and you might see them on the doctors' rounds but they're ready to go to the next ward. If they're on call well then you can always give them a ring but it sounds easy but sometimes they're just not available.*

This uncertainty as to what the patient has or has not been told influences the type of interaction that occurs between the nurse and the patient. Amy finds that she is very tentative in what she says at times and is forced to skirt around issues which she believes should be addressed. This is illustrated in the following extract in which Amy describes an actual situation which she found difficult.

> A2/17/7
> ***(...) often you're not aware of what they know but you don't want to probe too much as to what they know in case you... sort of say the wrong thing. (...)*** <One> ***Saturday morning I was reading*** <the nurses notes> ***when I came on*** <and> ***it said 'Mrs So-and-so... seen by Doctor So-and-so and told the results of C.A.T. scan'. (...) and I didn't know what the results were <and> I sort of had to weed my way through the doctors' notes and still couldn't find the results (...) it was really bad because (...) none of the nurses that were on knew and I mean it might have been something terrible (...) and we didn't really know so it was a bit of a tricky circumstance (...) we just had to fish our way through the day and we didn't quite know whether the results were clear or bad (...) the patient should have had a time to talk about the whole thing. She didn't seem distressed in any way but that didn't mean that she wasn't.***

Later in the same interview she notes:

> A2/19/4
> ***As far as no-no information goes, often you are just in a circ... situation that you are in the middle of it because you want to sort of inform your patient or allow them to discuss things but you're not too sure what they're meant to know at the time - from day to day it often changes, like if... they might want to wait till the relatives are there to tell them or... it's difficult.***
> ***(...) I wouldn't avoid it. There's sort of a way of discussing things without (...) giving them too much... you can give them information without it being really distressing information. I mean I wouldn't... you know what they're not meant to know, you're not going to tell them that they've only got six weeks to live or that their prognosis isn't very good cos they may not have been told that, and yet, if they have been told, well it's a good time to be able to talk about it.***

Thus Amy develops strategies to cope with situations of uncertainty in which she knows she must not divulge ***'no-no'*** information but feels she must also provide the patient with support should they have received, or be anticipating, potentially distressing information.

Communication between nurse and patient therefore becomes distorted and the type of interaction between them constrained.

Compromised professional values

During the first interview Amy talked about some interactions between nurses and patients which she obviously felt were important. She notes:

> A1/11/4
> ***There's times when you can really sit down and chat to somebody - not while you are giving physical care - like not while you're giving them a sponge or shower or making their bed or whatever - not while you're rushing past and "Hello Mrs So-and-so" or "How are you?" or "Have a good sleep last night?" - not those times - I'm talking about the times when you are free and you feel you want to give somebody a time when you can chat. (...) I find that's really important - just those are the times when someone has got the opportunity to ask questions. I don't believe you can find out where a person's at or assess fears that they've got (...) you can't do that unless you can sit down with them even in this sort of manner and have a chat - or for me I can't do that in a very beneficial way if I'm in the middle of doing something else or of I'm meant to be somewhere else.***

She also notes however that when the ward is busy this is one aspect of care tends to be omitted. She comments:

> A1/12/3
> ***I don't like to see that it can go but it does.***

Indeed, Amy refers to this as ***'a little bonus'***. Thus, what Amy sees to be an important part of her nursing practice comes to be seen as something outside, additional to, her normal nursing world.

Clearly short-staffing constrains much of Amys' nursing practice. For example, during the first interview she reflects on a recent time when the ward in which she works was particularly busy and notes:

> A1/13/1
> ***I remember I was really frustrated. Lots of things used to bug me in the sense of the quality of care you were giving and it was almost out of your... I couldn't change the situation. I would have liked to have changed the situation***

> ***but I couldn't (...) My cares were just the bare essentials sometimes - I'd just be able to do the most important things and it's just frustrating. You do what you have to do sometimes and it's all... you feel horrible sometimes (...) an old lady, you put her in and out of the shower, you do her hair for her, do her teeth, have a little chat as you're going... as you're doing it and pop her in a chair and tell her you'll see her later... or slap a magazine in front of her or give her a drink and it's so horrible. I think to myself "man if I was her I wouldn't feel very loved." That's only one example. Just focussing on the pre-operative cares, again you would be doing the best assessment you could with the time you had. Sometimes it wasn't the best.***

Another example of this frustration was provided during the fourth interview where she comments:

> A4/28/2
> ***...you actually tell someone you'll get back to them to have a chat about whatever and I often sort of say "Well, you think about it for a while between now and then and think up some questions". But sometimes you just don't get back to them and you get home and you remember (...) it's pretty frustrating. I hate that because I know if it was me I probably wouldn't ask someone else about it.***

Clearly Amy is aware that when the area in which she works becomes busy she is not able to provide the standard of care which she, as a professional nurse, feels should be provided. Much of the knowledge which underpins professional nursing practice is therefore not able to be expressed in nursing action as Amy provides '***just the bare essentials***'. Care beyond this minimal level comes to be seen as something extra provided over and above the usual nursing cares. Thus institutionally imposed workload constraints are seen to be 'normal', and nursing practice comes to be defined (limited) by these constraints.

These constraints also effect other aspects of Amys' practice world. For example, during the third interview she talks of how she enjoys teaching students when there is time but she notes:

A3/2/1
I feel as if I should be doing it sometimes and we're flat stick and there's no way I can.

This state of affairs was again discussed during the fourth interview.

A4/27/8
When you're busy there's a gap between what the ideal set-up would be in teaching <students> ***because really they're there for a learning experience and it could be the only surgical experience they get and there's a lot that you really want to give them a hand with or you might notice a gap in their knowledge that you want to help them with and you just haven't got the time.***

While Amy feels '***frustrated***' when she is unable to provide nursing standards which reflect her personally held professional values, she is unable to challenge the institutionally imposed constraints for they are seen to be outside her control. During the second interview she notes:

A2/2/2
(...) really it is quite short-staffed but, it's no worse than it has been lately. You tend to learn to live with it.

Short-staffing is clearly seen to be a 'normal', taken-for-granted part of Amys' practice world, hence the '***frustration***' of her professional practice goals is also seen to be 'normal'. To be satisfied in, rather than frustrated by her nursing practice Amy should be able to practice in accord with her own professional values, fully utilising her professional knowledge base. Since practising in this way comes to be seen as outside normal expectations then satisfaction with her nursing practice may also come to be seen as beyond her 'normal' expectations ie. not something she has right to expect of the work situation. Alternatively, her satisfaction with the work setting may come to be derived in meeting institutional expectations of efficiency, not in maintaining high professional practice standards.

FINAL INTERVIEW

The final interview with Amy lasted over 3 hours during which time she was provided with an opportunity to comment on the draft of the synopsis and commentary sections of this chapter. She was also able to reflect on the experience of participating in this present study.

Amy expressed general satisfaction with the way that the data had been presented and the analysis made. Although she commented on many parts of the draft these comments were in the form of agreement and/or expansion and she did not request any changes in the content.

During this final interview there was some evidence that Amy was now able to exercise personal and professional agency in ways that she was unable to do so at the time of the earlier interviews. For example, in contrast to her earlier experience of administering a dose of the drug 'Dilantin' which she clearly believed was excessive (see pp.40-43) Amy described a situation in the new ward in which she now works where she was able to challenge a doctor over a medication order which she did not agree with, and about which she believed that she knew more than the doctor. She noted:

> ***...as far as our knowledge goes and our experiences with patients its not advisable to put someone straight on to slow release Morphine, it's better to control them on 4 hourly medication and then look towards M.S.T. medication, but he wanted them on M.S.T. and even though we were really quite tactful about it he really didn't like it that we were telling him "I'm sorry, we've been working with*** <this type of patient> ***for a year". We didn't tell him that he doesn't know anything but we had to do it really tactfully without saying "Look, you don't know what you're talking about". (...) Even though initially he was quite defensive and got quite rude about it he eventually mellowed down a bit and came back afterwards and said "Chart her 4 hourly*** <medication> ***and see how we go.***
> ***(...)***
> ***we wanted to make a stand that we weren't going to give a patient something that we weren't happy with(...).***
> [Are you more able to do that now?]
> ***Yeah. Definitely... as long as I believe in what I'm doing or as long as I know... probably because of my knowledge base now and probably just maturity as a person - more assertive.***

> *I've learnt now you've got to be - you just get drowned in the system otherwise, you're moaning all of the time but you've actually got no reason to moan unless you do become more assertive and that because you've got to make a stand, otherwise you end up doing things that you really don't want to do, or don't think you should be doing, or you just don't feel happy doing....*

Nevertheless, Amy stated that she still experiences some difficulties in challenging the authority of the doctor.

> *(...)I guess it's still a challenge sometimes, I wouldn't automatically do it, I'd sort of hesitate or discuss it with somebody else... usually my workmates...*

And expanding on the discussion of the way in which nurses orienting their behaviour to accommodate individual doctors' approaches (see pp.43-47) Amy noted:

> *That may be the way it is but it's not the way that the majority of nurses, myself anyway, believe it should be but... it is the way it is.*

She is also aware that nurses may perpetuate existing relationships by their behaviour. This is evident in the following quote where Amy was discussing the notion that nurses often ask questions on behalf of patients when they have not been able to ask the doctors themselves.

> *It's almost like putting a plaster on the problem, it's just going to continue.*

In all of the above comments Amy demonstrates a considerable degree of reflectivity. This is also evident in the following when, questioned about her feelings about her experience of participating in this present study she replied:

> ***I remember when you first asked me I thought "I've never had an interview like this before" but, you forget that you're on tape... you can probably tell that when I raved on... It was all relevant in a round about way... to the system and to the way things are.***
>
> ***(...) I've been getting encouragement from this whole series of interviews and that's made me more personally aware of the need to educate and to be open to education from other people and more aware of the different communication***

interactions. I think when things are down on paper... I see the concrete things written down that I said, what my attitudes were, I know they've changed and it doesn't happen overnight.

CHAPTER SIX

'EMILY'

PROFILE

Emily graduated from a hospital programme at a large regional hospital 5 months prior to her first interview. She worked as a staff nurse on pool duties (ie. she was not assigned to a particular ward but worked each shift in the area where she was required) for two months after graduation. Since then and during the time of the first three interviews she worked as a staff nurse on an acute care (surgical) ward. Shortly before the fourth interview she transferred to another surgical ward, again as a staff nurse.

SYNOPSIS

One of the first major themes to emerge from the interviews with Emily was the notion that for effective nursing practice in the work setting some types of knowledge are more valuable than others. Valuable knowledge is seen by Emily to be that which allows the nurse to function 'efficiently' in the established, less than ideal, but unchallengable, work environment.

Emily clearly sees that in order to really know something requires personal action and/or confirmation by others with more knowledge derived from action (particularly charge nurses). While she recognises that nurses who have graduated from technical institutes have different knowledge and experiences she sees that this knowledge is less valuable than that of hospital graduates in that it has not been derived from action in the same way. She sees that this knowledge does not prepare 'polytech' nurses <those whose nursing education is based in technical institutes> to work 'efficiently' in the 'unavoidably imperfect' work environment.

(pp.64-67 & p.70)

A second, related theme to emerge during the interviews was Emily's experience of socially determined constraints on her professional practice. Emily notes that there are some aspects of her practice, and practice in general, that are not as she believes they should be.

For example, while she believes that it is desirable for nurses to be present when doctors are explaining aspects of care to patients, and when doctors on their rounds are visiting the patients for whom the nurse is caring, Emily notes that this seldom occurs. In each of these cases she sees that her ability to act is constrained by organisational factors that are by implication 'natural', hence immutable. (pp.67-68)

In addition, Emily explains that the personal factor of '***shyness***' prevents her from joining in on doctors' rounds although she believes that it would be in the patients' best interests for her to do so. In doing so she takes personal responsibility for defects that are essentially structural in nature.

Emily explains that it is the behaviour of individual consultants that contributes to her reluctance to join in on 'rounds'. If they, as individuals behaved differently then she believes she may be able to overcome her shyness. Some consultants, she notes, just happen to be '***fast and efficient***', may '***fail to be chatty***', or may be '***abrupt***'. They are however, probably '***nice men***' anyway; something prevents her from seeing their 'true personalities'.(pp.68-69)

The above form of explanation the level of the individual, when seen as the complete explanation, suppresses other types of analysis in particular, consideration of the social conditions that inhibit personal agency. In effect, Emily is 'objectified' in that she perceives her practice as unavoidably constrained by factors over which she has no control (including her own 'shyness').

Although Emily acknowledges that others, particularly patients, have difficulty interacting freely with consultants she again treats this as though it were simply a personal problem. She takes as given the social relationships and practices which are reflected in the patients' reluctance to ask questions of consultants and her intervention, acting on behalf of the patient, does little to challenge, and may actually serve to support and perpetuate existing social conditions which constrain the personal agency of patients. (p.70)

In each of the above examples one level of belief, in the 'naturalness' and 'unchallengability' of socially determined constraints, dominates another, the professional values underpinning Emily's practice. This disjunction was further illustrated when Emily described the dissatisfaction she and other nurses experience when the ward is particularly busy. That

she believes other nurses experience the same sense of dissatisfaction is not however seen as providing the impetus or possibilities for change for Emily has not developed a critical awareness of the social conditions constraining her actions. 'The system' merely exists and is outside the control of all nurses.

A third, again related area of importance to emerge from the interview data is the notion that there are at times clear contradictions in Emily's descriptions and interpretations of her social setting and the practices which she observes and participates in. Some of these evidently find their origin in contradictory understandings and expectations prevalent within the work setting.

One example of such disjunctions is found in Emily's descriptions and interpretations of the experience of being '***in charge***' on a shift. Emily implies that:

a) When you are '***in charge' 'you've got to know everything***' about all patients (an understanding she shares with other social actors
b) you can't reasonably achieve this (personal knowledge)
c) and hence, doctors '***don't expect***' nurses to know everything (that would be unreasonable).

The feelings that Emily reports experiencing when she is asked questions that she cannot answer ('***decidedly stupid***' and '***silly***') are again interpreted as a personal response. She does not see them as symptomatic of wider institutionalised relationships and consequent expectations. (pp.71-72)

Emily also reports feeling caught between doctors and patients in that she is often expected to provide for the needs and demands of both groups and, in the process, is able to satisfy neither. She provides two examples of this where, in order to act in what she perceives to be the best interests of particular patients she needs to contact the doctor and get him to come to the ward, while at the same time she knows that she should not disturb the doctor unnecessarily.

In each of these cases the doctor tells Emily that he is too busy to come to the ward. The notion that the doctor, and his work, is most important and other social actors must organise themselves around him is both communicated and reinforced in such everyday interactions between nurse, doctor and patient.

While Emily recognises that her frustration lies in these conflicting expectations she again does not place her interpretation in the context of the institutional structure and power relationships within it. She therefore does not surface the social conditions that contribute to her frustration. Such uncritical reflection enables her to recognise the frustrations that these conflicting demands impose but not to develop strategies to overcome them.
(pp.73-74)

Throughout the interviews Emily does demonstrate a considerable degree of reflectivity in that she is able to point to contradictions in the work setting and disjunctions in her own beliefs and understandings, and in those of other social actors. She does, at times, momentarily surface the ideological beliefs that perpetuate existing social conditions. However, while she does show a momentary appreciation of the socially negotiated nature of existing conditions she does not maintain this consistently and reverts to explanations that see existing relationships and practices as 'natural' and unchallengable.
pp.75-76)

EXTENDED COMMENTARY AND INTERVIEW DATA

Knowledge and Responsibility

Emily had been working as a staff nurse on the acute care ward three months months prior to the first interview. In the following extract she recalls her initial experiences as a new staff nurse.

> E1/2/2
> <As a staff nurse Emily felt she was> ***expected to know more and you couldn't pass the buck like, as a student you'd say "Oh, just a moment. I'll go and ask the staff nurse." whereas as a staff nurse you can't - you sort of realise you're it and you have to know a bit more about what you're doing - take a bit more responsibility.***

Emily expresses an initial feeling of lack of confidence in taking on this new responsibility. She implies that really knowing something requires personal action that only occurs over time.

Being told is one thing but doing is what is really important.

E1/4/1
(...)it's probably the best way to learn - I mean, people telling you stuff it often goes in one ear and out the other anyhow - I mean, you know, until you actually do it you often don't take much in especially at first because you're so scared, I think.

This lack of early confidence was reexamined in the third interview. Emily again implies <u>really knowing</u> requires action (and confirmation by others with more knowledge derived from action).

E3/27/5
(...) before my practice was correct... but I just wasn't confident that it was correct.
[So what's given you that?]
Just getting and doing it and getting positive feedback again.
<Particularly from the charge nurse.>

The value she places on action as a basis for knowledge is reinforced in Emily's discussion of the problems faced by new graduate comprehensive nurses (who have received their nursing education in programmes based in technical institutes not hospitals).

E3/4/6
I think I've been lucky in my hospital training just for adaptability. We've got a new staff member who's been going... three months... she's polytech-trained... and I'm sure I was more adaptable at her stage than she is.
(...)
I think they have a disadvantage there. They haven't had the... say, the number of patients that we would have had. Like, we would get six patients or whatever and have to go to it, so they haven't had the practice at organising time and workload and they find it difficult and then, with students coming to them - like through our system the senior students dealt with the junior students and showed them what to do...

Emily sees 'polytech' graduates as having different (in many respects less worthwhile) abilities because of the nature of their education and consequent lack of knowledge crystalised in action.

E4/14/8
I think <hospital trained nurses> ***are used to being under more pressure and you've spent longer in each... different ward situations, so when you get thrown into different situations you're... you can cope better. (...) if they've had***

that pressure they've always had someone they can... a tutor they can fall back on... who can say "Look you need to organise your time a bit better. How about you do it this way." Whereas hospital training teaches you that you have to organise yourself. (...) They are good at sitting and chatting to patients... but sometimes they choose the wrong time to do it.

Emily recognises that the 'polytech' graduates have different knowledge and experiences, hence abilities and priorities, but sees these as less valuable, even detrimental to effective practice in the actual work context. To her, useful knowledge is that which allows the nurse to function 'efficiently' in an established, somehow less than ideal, but unchallengable, work environment.

E4/15/2
I guess they're used to giving the best care they can to two people or whatever, whereas we're used to having to give the best care we can to a number of people.
[And that best care...?]
Can sometimes be not as good... but they I think get a lot more frustrated at, say, having eight patients and going home feeling they haven't done all the things for any of them... they haven't almost learnt that little things... little physical things you can miss out on (...) and I guess they get more patient education as a result but another of their patients might miss out altogether.
(...)
[So you're used to (...) being really pushed in terms of time whereas you don't think that they have had that.]
Yes.
[Do they pick that up fairly quickly?]
I think that it takes them about six months...

In the following extract there is evidence that Emily sees as contradictory the conditions in which knowledge is developed. While knowledge derived from action is, as described above, viewed as highly valuable when attributed to staff nurses, it is seen as less valuable when attributed to enrolled nurses (nurses who have qualified from 12-18 month hospital based programmes).

E2/11/1
[Do the doctors deal much with enrolled nurses?]
No. Not really. Not at all really.
[Why is that?]
I think they just feel that staff nurses are more responsible... which I guess is fair enough considering we've had longer training but, looking at the enrolled nurses on our ward, if I was a doctor I wouldn't mind at all dealing with them.

> [How do you feel the enrolled nurses feel about <doctors> not interacting with them?]
> ***Some of them are quite happy. Some of them would rather.... you know... just be a straight nurse. That's all. Others... one's who've been there a bit longer would rather have a bit more responsibility and deal straight with the doctor (...) one's been there for four years, I guess, and she'd know as much about what's going on around the place as I would - more... a lot more probably.***

While enrolled nurses who have been working in the area for some time are seen as having gained useful knowledge, this is not recognised as being as valuable as the knowledge accumulated by staff nurses in the course of their 'training'. They are therefore seen to legitimately hold less responsibility.

In the above extract Emily refers to some enrolled nurses <particularly those who have not worked in the ward as long> as preferring to be '***just a straight nurse***' Here Emily appears to place a lesser value on '***straight nursing***' relative to the more responsible position of the staff nurse, who is presumably something more (better) than '***a straight nurse***'.

It appears then that knowledge is assumed to be associated with position and legitimises the 'responsibility' associated with that position. The view that registered nurses have more knowledge, and are therefore more responsible, is seen to explain the different relationship between doctors and registered, as opposed to enrolled, nurses.

Social constraints and professional practice

Emily notes that there are some aspects of her practice, and practice in general, that are not as she believes they should be. For example, during the first interview Emily states that it is desirable for nurses to be present when doctors are explaining aspects of care to patients. She notes however that this seldom occurs.

> E1/13/4
> ***(...) unfortunately (...) you've often got another, say, four or five patients and you just haven't got time to be standing in there while the doctor's there because you might have someone else going to theatre, or you know... all sorts of demands. But if possible I think it's good if you can be there while the doctor's there.***

Emily appears to accept that her practice is constrained by factors that are a 'natural' part of the practice setting and hence outside her control. It is simply 'unfortunate' circumstances that prevent her acting in the way that she perceives as being in her patients' best interests.

Emily also notes that it would be desirable for nurses to join in 'doctors rounds' where they are visiting the patients that she is caring for. She states, however, that this is not what usually happens.

> E1/28/4
> ***(...) the charge nurse will usually tell you, she writes it in the report and lets you know exactly what's happening*** <with patients>, ***but it would be good to go round, I think, and join in with your particular patients.***
> [Would that be possible?]
> ***I don't know... unfortunately doctors' rounds often coincide with morning tea breaks and afternoon tea breaks and things like that and then - you know - it's not really too possible...***

Again she sees that her ability to act in the way she would wish is constrained by organisational factors that are by implication 'natural', hence immutable; it is simply 'unfortunate' that doctors' rounds often coincide with tea breaks etc.

In addition, Emily explains that she feels she is unable to join a doctors' round in a way that would presumably interfere less with her work i.e. when the doctors reach the patients for whom she is caring. She states:

> E1/28/5
> ***(...)I'd feel a bit shy about just popping into a doctors' round where I hadn't started out.***

This inability is explained by reference to the personal factor of feeling '***a bit shy***'. By implication Emily herself is therefore to blame; if she was less shy she may be able to act in what she sees is the best interests of her patients. Here Emily has not penetrated beyond an individual level of explanation - her 'shyness' is a 'personal problem', it is not viewed in the context of wider institutionalised power relationships. To a large extent she thereby accepts personal responsibility for defects that are essentially structural in nature.

When asked what it is that makes her shy of consultants Emily remains at an individual level of explanation. She states:

> E1/29/1
> ***(...)doctors often like I said before put up an abrupt front... don't spend time...***
> [So it's with you as well?]
> <Emily had previously described a similar pattern of interaction between doctors and patients.>

> ***Yes, it can be. More the consultants... the junior ones are much better but, it varies from consultant to consultant - some of them seem incredibly grumpy... whereas others of them seem really nice and wouldn't mind you bowling in... on a round but... generally I'm a bit, a bit scared of them.***

Emily thus implies that it is the behaviour of individual consultants that is responsible for her discomfort; any difficulties experienced arise as a result of the personalities of particular consultants. If they, as individuals, behaved differently, then Emily believes that she may be able to overcome her shyness.

When asked what it is about consultants in general that could lead to nurses feeling scared of them Emily replies:

> E1/29/3
> ***I don't know. It seems... I don't know... they just... they seem more distant... and fast and efficient and they don't want to waste time in one ward... and some of them just aren't plain chatty or anything... just abrupt and... they're probably quite nice men when you get to know them but...***

Emily accepts then that there is something about the relationship between herself and individual consultants that makes it difficult for her to interact with them freely but which also prevents her seeing their 'true personalities'. Some consultants just happen to be '***fast and efficient***', they fail to be '***chatty***' and they are '***abrupt***' in the ward setting; but they are probably '***nice men***' anyway.

Emily accepts that consultants can legitimately behave in this fashion. As with the organisational constraints identified above, such relationships, while not seen as desirable, are accepted as 'natural' and therefore unchallengable.

This form of explanation (at the level of the individual) does contain significant elements of truth for Emily. She and other nurses do feel 'shy' of consultants, and some consultants do seem more intimidating than others. Some consultants seen by Emily as intimidating in the work setting probably would interact differently with her in other circumstances. However, when seen as the complete explanation personal attributions suppress other levels of analysis, and the development of critical theories that may allow Emily to exercise personal agency. In effect Emily herself is 'objectified' in that she perceives her practice as unavoidably constrained by factors over which she has no control (including her own shyness).

While Emily acknowledges that she has difficulty interacting freely with consultants and explains this in terms of a 'personal trait', shyness, she is also aware that patients often have similar difficulties and may feel unable to ask questions of doctors. She notes that in such situations it is sometimes necessary for her to intervene on their behalf.

> E1/27/5
> ***Some*** <patients> ***need a fair bit of prompting and others of them you have to be the patients' advocate. They're very scared of doctors, very frightened (...) and so you have to ask on behalf of the patient, you know - "Mrs So-and-so was wondering..."***

Emily again treats the above situation again as though it were a personal problem, this time for the patient. She takes as given the social relationships and practices which are reflected in the patients' experience of their situations. Her intervention, acting on behalf of the patient, does little to challenge, and may actually serve to support and perpetuate existing social conditions which constrain the personal agency of patients.

That Emily has not fully penetrated the contradictions evident in the work setting is further evidenced by her attitude to 'polytech nurses'; she sees them as being even more frustrated by the constraints of practice than Emily herself or other 'hospital trained' nurses like her. Emily, it seems, believes the education of 'polytech nurses' has not prepared them adequately to accept the unavoidably imperfect work environment. Indeed, as described above (pp.64-66) her knowledge of action is seen as more valuable because it allows her to function 'efficiently' within these preexisting imperfect structures.

In each of the above examples one level of belief, in the 'naturalness'/ 'unchallengability' of socially determined constraints, dominates another, the professional values she sees as underpinning her practice. It is not surprising then that, given such a disjunction, Emily reports at times feeling frustrated. For example, during the fourth interview she discusses the dissatisfaction experienced when the ward is excessively busy. She notes:

> E4/10/5
> ***That's when it's hardest for both the nurse and the patient because the nurse usually goes home feeling unsatisfied with the day.(...) not necessarily because you've failed to explain*** <things to patient> ***but just because there's several things like that you haven't done.***
> [The lack of satisfaction comes from what in particular?]

> ***Just not being able to spend that extra little bit of time with patients, be it for their basic physical care or... be it just for talking things over with them. You know... just spending that time to get to know them a bit better, I guess, to build up this relationship so that they can trust you and, it's nursing.***

Emily also notes:

> E4/11/9
> ***(...)you often hear nurses say "I didn't like it today"(...) "I just didn't get the satisfaction out of it".***

That she believes other nurses experience the same sense of dissatisfaction is not seen as providing the impetus or possibilities for change for she has not developed a critical awareness of the social conditions constraining her actions. 'The system' merely exists and is outside the control of all nurses.

Contradictictory Beliefs and Expectations

At times in there are clear contradictions in Emily's descriptions and interpretations of the social setting and the practices which she observes and participates in. Some of these evidently find their origin in contradictory understandings and expectations prevalent within the work setting.

An example of this was provided by Emily when, during the third interview, she discussed her feelings having been '***in charge***' for the first time on morning shifts. This, she described, involved '***liaising***' between the various categories of hospital staff and between staff and patients and relatives. She noted that at first this was '***quite a strain***' because:

> E3/1/3
> ***(...)just... everyone's at you.***

Emily focusses on being present on doctors ward rounds as a significant element of being '***in charge***'.

> E3/2/1
> ***(...) and you've got to know exactly what's happening in all the*** <ward, with> ***everyone in the ward cos you've got ward rounds too - the doctor's ward rounds - and they say "Well what's happening to Mr So-and-so?" and "Where is he at?"***
> [What happens if you don't...<know>?]
> ***Sometimes I don't but hopefully there's someone in the office who does, but, if not, I can always say "Look, I'll just go and find out. I don't know." (...) I feel decidedly stupid.***

> [And yet it's probably not reasonable to expect that you would know everything about everyone.]
> ***I don't think they do expect it but you just feel a bit silly when you don't.***

Here there is a disjunction between the different ideas Emily is expressing. These disjunctions are reflective of contradictions between ideological understandings shared with other social actors (and consequent expectations) and Emilys' own personal knowledge and expectations as a professional nurse. She appears to believe:

a) that when you are '***in charge***' '***you've got to know everything***' about all patients (an understanding shared with other social actors)

b) you can't reasonably achieve this (personal knowledge)

c) and hence doctors '***don't expect***' you to know everything about all patients (that would be unreasonable).

The feelings that Emily reports experiencing when doctors ask questions she cannot answer ('***decidedly stupid***') are again interpreted as simply a personal response ('***you just feel a bit silly***'). She does not see them as symptomatic of wider institutionalised relationships and consequent expectations.

Charge nurses are expected to liaise between these nurses and the medical staff and, by virtue of their position, are expected to know what is going on with all patients and to convey this information to doctors when they require it. Hence, when she is standing in for the charge nurse she expects this of herself (even though she, at the same time, knows it is not really reasonable or possible).

There are some distortions in the messages Emily is receiving. While it would evidently be unreasonable for doctors to <u>expect</u> her to know everything Emily, at least to some extent, expects this of herself (otherwise she would not feel stupid). The implication is that a nurse who is competent <u>will</u>, in such situations, be able to answer the doctors' questions. Yet, as indicated by Emily above (pp.67-68) the nurses who presumably have the greatest knowledge of the particular patient (those who are actually providing the care) seldom are present or participate on ward rounds.

Demands of practice - conformity/passivity in face of authority

Emily reports feeling caught between doctors and patients in that she is often expected to provide for the needs and demands of both groups. These needs and demands at times conflict with one another and Emily is left in the position of being able to satisfy neither party. During interview 1 she notes:

> E1/14/3
> ***(...)Sometimes you feel like you're piggy-in-the-middle. You like to do the best for the patient... you ring up the doctor... you get him along and then he really snaps at you... We're sort of in a no-win situation.***

She gives the following example:

> E1/14/4
> ***(...) we had a patient going home the other day and the doctor had just been up to see him. He'd been charted these drugs and he had to go all the way to*** <another city>. ***I rang the doctor and said "Look, can you come and*** <write a discharge prescription for> ***these drugs?" And he said "Look, I'm busy at the moment", and slammed down the phone, you know, you sort of... the poor patient's got to head off to*** <another city> ***and has to hang around until this doctor comes, which could be later on in the afternoon.***

In situations such as those described in the above extract Emily knows that she should be acting, in line with her professional values, in the best interests of the patient. To do this she must arrange a discharge prescription as soon as possible so that he can leave the ward and travel to his home town.

She also knows that it is expected that she should not disturb the doctor by ringing him when he is busy with more important matters. (This expectation is reflective of shared ideological beliefs about who, and whose work, is most important in the institution). Emily, is not, however, in a position to know whether or not the doctor is busy with other things. Nevertheless, she is left with the impression that the doctor is annoyed (he slams down the phone) because she has disturbed him when he is busy.

In order to meet the patients needs Emily must persuade the doctor that there is an important reason for him to come to the ward. It is not expected that the doctor will have anticipated the patients prescription requirement. Nurses are expected to be responsible for anticipating patient needs on behalf of doctors.

This experience is apparently not an isolated one. Emily comments:

> E1/17/3
> <being caught> ***in between the patient and the doctor (is) what you find being a staff nurse a lot more though (...) Being in a no-win situation... between patients and doctors(...)***

She then goes on to describe another situation in which she felt this way. In this case she had phoned a doctor in order to obtain medication for a patient but was unsuccessful.

> E1/17/4
> (...)<The patient> ***was really sore and he*** <the doctor> ***wouldn't take my word for it that this guy was really sore. (...) I said "Well, what about such-and-such?" "Oh, no, that won't work" and (...) He sort of slammed down the phone and left me hanging in mid-air. (...) I was getting bombarded from both ends. The patient was saying "Why didn't you say such-and-such?" and the doctor was saying "Well, why don't you tell him such-and-such?"and (...) I was being landed in the middle almost. (...) And then*** <you> ***sort of get told "Oh well, you nurses don't know what you're doing anyhow."... from both ends...***

Although in each of the cases described in the above extracts Emily judges that it is important that the doctor come to the ward she is not able to get him to do so. Nor is she able to ask him to make other arrangements to meet the patients needs. The notion that the doctor is the important person around whom others must organise themselves is clearly both communicated and reinforced in these everyday interactions between nurse, doctor and patient.

While Emily recognises that she is placed in the frustrating position of being unable to meet her own expectations as a professional nurse, the expectations of the patient, and the expectations of the doctor, she does not place her interpretation in the context of the institutional structure and the power relationships within it. She therefore does not surface the social conditions that contribute to her frustration. Such uncritical reflection enables her to recognise the frustrations that the conflicting demands impose but not to develop strategies to overcome them.

Reflection and Action

Throughout the interviews Emily does nevertheless demonstrate a considerable degree of reflectivity. She reflects on her own behaviour and the behaviour of others and is at times able to point to contradictions in the work setting and disjunctions in her own beliefs and in the beliefs of others. For example, during the second interview Emily comments:

> E2/18/1
> ***I guess it's that real... doctor... surgeon up there, nurse sat down there type of situation, which is bad, but you feel it.***
> [I wonder why it's like that?]
> ***I think there are lots of nurses would be the same.***
> ***(...)***
> ***I guess it could be partly that the nurses tend to think they*** <the doctors> ***know more whereas often maybe they... you know they've got more knowledge, which they have, but often they haven't got more knowledge about that particular patient... sort of specific knowledge to that patient.***

Clearly Emily is to some extent aware of the contradictions involved in the belief, shared with other social actors, that doctors should legitimately dominate within health (or sickness) oriented institutions. She is able to, at least momentarily, penetrate the ideology which maintains existing relationships and recognise that disjunctions exist. She does not however truly confront or consistently see beyond the prevailing notion that doctors are legitimately seen as having the most knowledge, or at least the most valuable knowledge, and are therefore legitimately the most powerful group around whom institutional practices are organised.

Reflecting at the end of interview 4 on the patterns of interaction between nurses and doctors Emily comments:

> E4/22/7
> ***(...)I think we need to stick up a lot more for ourselves with the doctors and stick up for the decisions we make and encourage our patients to ask questions of the doctors... it's often better the question coming from the patient. (...)***
> [What is it that stops nurses sticking up for themselves at the moment?]
> ***I think it's still the basic um, I don't know, I think that they still feel a lot smaller than the doctor (...) whereas they shouldn't, but they do.***
> ***(...)***
> ***I think it's not as bad as it was. I do think it's changing but it's still there.***

[Do you still feel it yourself?]
Mm... but... I mean it depends a lot on the doctor too... his sort of attitude I guess towards nurses and that comes across and you sort of... kind of shut up and won't say something depending on what he's like.
(...)some are very stand-offish and you don't feel you could approach them. They're just not that sort of person.

Although Emily is able at one level to see that things could and should be different, at another level she is still very much constrained by the ideology of the institution. In the above extract she shows some appreciation of the socially negotiated nature of institutional relationships. Yet she reverts to personal explanations that reflect an acceptance of the belief that doctors have the power to set the scene for the interactions with nurses and patients; that they legitimately control the type of interaction that is possible. Existing relationships thus continue to be seen as legitimate, 'natural' and unchallengable.

FINAL INTERVIEW

The final interview with Emily lasted approximately one and three quarter hours during which time the draft of the synopsis and interview data and commentary sections of this chapter were discussed.

In relation to the section in which she had commented that '***some nurses prefer to be just a straight nurse'*** she asked that clarification be made in that she believes that:

... I think every nurse has got a responsibility to be more than just a straight nurse, whether they are enrolled nurses or staff nurses. Straight nursing would be basic physical care and I think every nurse has got to go beyond that and deal with the whole person.
(...)
Enrolled nurses can't be a primary nurse but they should be sticking up more for the patients' rights than they do. I can understand that some would feel very reticent doing that and maybe they should go to a staff nurse and together they should do it.
[What is the difference between the enrolled nurse and the staff nurse in those circumstances?]
I think the enrolled nurse would be looked down on a bit more by the doctors than say a staff nurse - I think again it's an institutionalised thing. I think they feel that they shouldn't be saying it because of the power thing and because they feel they're at the bottom of the rung.

Apart from requesting this clarification Emily stated that overall she was very satisfied with the content and interpretations made. Like Amy, she indicated that the interview experience had been a useful one and she demonstrated a considerable ability to reflect on her experiences in the practice setting, the interview experiences and the analysis. This ability is evident in the following excerpts.

> ***You don't realise how much it is the institution till you read something like that. Then you realise, goodness,it isn't really my problem, it shouldn't be my problem, it's everybody's problem and we should all work together and do something about it.***
>
> ***I think at that stage I was very much a younger staff nurse and I think I'd be a bit more prepared to challenge things now, more assertive.***
> [Things that you were experiencing at that time, have you been able to move beyond them?]
> ***Some... some of them are still there...***

Later she commented:

> ***I agree with how you've interpreted it. I really didn't think about how what I was saying could be interpreted but I think you're right. I think I've matured in my nursing, I'm more assertive. (...)***
> [Was it helpful to analyse things in this way?]
> ***I think so - I think it makes you more aware of what you basically think of as right without... but at the same time knowing that you're not right. You don't think about challenging things whereas you should.***
> ***(...)***
> ***I think this*** <study>***... what you are doing will be good, open peoples' eyes a bit more, open other nurses eyes as to how they think without thinking about it. We don't really stand back from it*** <the practice setting> ***enough do we. Often we're too busy to actually take a bit of time out and look and understand what's going on.***

CHAPTER SEVEN

'CATHY'

PROFILE

Cathy is a woman in her twenties who graduated from a hospital based programme as a Registered General and Obstetric Nurse eighteen months prior to the commencement of the interviews. Her basic nursing education had been undertaken at the same hospital at which she was working as a staff nurse.

On becoming a staff nurse Cathy had worked in an acute care ward for several months. She had transferred to an acute care surgical ward several months prior to the first interview and worked there during the time that the first four interviews were conducted.

SYNOPSIS

The major theme that emerged from the interviews with Cathy was the notion that her professional beliefs and values are at times compromised in the face of what she and other social actors perceive to be the legitimate authority of other institutional members, particularly doctors and the ward charge nurse. As a consequence she is not always able to utilise effectively the knowledge that she has developed as a nurse, and that she believes should underpin her nursing practice.

This theme is evident, for example, where at interview there are clearly expressed contradictions between professional values which encourage Cathy to exercise professional judgement in relation to patient care, and the organisational structure in which the charge nurse exercises control, and is seen as having the legitimate authority to do so. According to Cathy the charge nurse makes, or oversees, many decisions that she, as a registered nurse, should be making independently.

There is apparently little consistency in the messages Cathy receives from the charge nurse. For example, at times Cathy is told to '***take the initiative***'. Often she finds however that her decisions are overridden or that the charge nurse '***would rather have done it herself***'. Thus Cathy learns to check with the charge nurse before making decisions even though she sees herself as being perfectly capable of making them. (pp.81-84)

Although she is clearly frustrated by this Cathy explains her inability to act in terms of a personal 'failing' - shyness. She indicates that if she was more assertive then the situation would be better. As she notes that she has never seen other nurses stand up for themselves, for example, when they are reprimanded unfairly by the charge nurse, she presumably sees that other nurses share the personal failing of shyness. She does not recognise that the constraints on action are a reflection of the institutionally sanctioned and intersubjectively accepted relations of power within the institution. (pp.84-85)

Contradictions are also evident in Cathys' desire to provide a standard of care that conforms to her expectations as a professional nurse while at the same time she believes she should be able to cope, and certainly must be seen to cope, with the workload allocated to her by the charge nurse. In relation to this Cathy reflects uncritically and expresses contradictory beliefs. Her personal experience tells her that coping with such workloads in a way that conforms with her professional ideals is impossible. Yet she also believes that she must be able to cope because the charge nurse, the legitimate authority on the matter, '***thinks you can cope with that list so you should***'.

Cathy is aware that other nurses experience similar difficulties and, although she believes that it would be unreasonable to expect them to cope in this way, she knows that they, like her, will not willingly admit that they cannot. She evidently shares with other social actors the understanding that a 'good' nurse is efficient (in line with institutional expectations) and copes with the workload allocated by the charge nurse.

Cathy inevitably experiences a level of discomfort in holding these contradictory beliefs. Should she ask for help then she will fail measure up to the expectation that a 'good' nurse (in terms of institutional values) copes with the workload allocated to her. On the other hand, if she does not ask for help she will not provide the standard of care that her professional values dictate she should.

The recognition that other nurses also experience this pressure does little in the way of helping to surface, and indeed may actually serve to mask, the contradictory nature of these beliefs. Cathy notes '***it doesn't seem to be in our nature to ask***' for help, '***it seems to be universal I think***'. Here she explains as 'natural' and universal the intersubjectively held beliefs about coping - nurses must cope and must not ask for help. Thus her personal knowledge and professional values, which link coping with quality care are not seen as having a significant place in the 'real' practice setting (which is itself seen as natural and unchallengable). (pp.85-87)

Further contradictions between personal and professional knowledge and intersubjectively shared beliefs and social practices are evident in Cathys' acceptance of existing relations of power wherein the consultant is seen to legitimately dominate over both nurses and patients even though Cathy acknowledges that this is not necessarily in the best interest of either nurses or patients. This is particularly evident where Cathy takes-for-granted the legitimacy of the doctors' control over certain kinds of information even though she sees that this control is exercised in ways that she believes are detrimental to the wellbeing of patients, to her own relationships with the patients she is caring for and that, as a consequence, reduce her ability to practice effectively.

Specifically, Cathy finds that her interactions with patients are constrained when she is forced to tread carefully to avoid touching on information that is the legitimate domain of doctors - information regarding the overall prognosis of the patient. Although she believes that patients have a right to have such information she does not see it as her perogative to divulge it. As a consequence Cathy finds that her relationship with some patients becomes one of deceit rather than openness in that she is finds it necessary to lie about, or at least conceal from the patient, what she does in fact know. (pp.87-89)

Cathy states that it is '***unfair***' that patients are at times deprived of information to which she believes they are entitled. She reports feeling '***guilty***' that this situation exists. However she regards it as totally outside her control and takes for granted the social structures and understandings which support this and constrain her freedom to interact openly with patients. (pp.89-90)

The perception that doctors legitimately control certain types of information also extends from the assumption that they are the only person who can legitimately judge whether or not a person is dying. They are also seen to be best able to determine precisely how much other social actors should be told.

Communication is at times distorted, for example, the doctor tells the patient '***that it's an uphill battle***' and from this the nurse interprets that the patient is '***terminal***'. She is not however sure that the patient has interpreted the message in the same way although she '***thinks he knows***' and her own interactions with the patient are necessarily distorted. While nurses (and presumably patients) may 'know' that the patient is dying they remain uncertain until the legitimate authority, the doctor, confirms it. (pp.90-91)

Given this overall climate of distorted communication and lack of openness it does not seem surprising that Cathy, and other nurses, report that they feel uncomfortable dealing with dying patients. They explain this discomfort in terms of a personal failing rather than surfacing the contradictions between their personal and professional knowledge and beliefs and the intersubjectively shared beliefs and institutional expectations. Thus, existing practices, reflective of and perpetuating existing social relationships continue unchallenged. (pp.91-92)

EXTENDED COMMENTARY AND INTERVIEW EXCERPTS

Professional values compromised in the face of perceived legitimate authority

A major theme that emerges from the interviews with Cathy is that her professional values are at times compromised in the face of, what she perceives to be, the legitimate authority of others. As a consequence, she finds that she is at times unable to utilise effectively the knowledge that she knows she has developed, and that she believes should underpin her practice. This is illustrated in several different issues which she discusses during the course of the interviews. For example:

a) There are contradictions between professional values (which encourage Cathy to exercise professional judgements in relation to patient care) and the organisational structures in which the charge nurse exercises control and is seen as having the legitimate authority to do so.

b) Contradictions are evident in her desire to provide care to a standard that conforms with her professional values while at the same time she believes that she should be able to cope with the workload seen to be appropriate by the charge nurse.

These two themes are discussed below.

Exercising professional judgement

An important defining characteristic of a professional group is the notion that a body of knowledge is accumulated and members of the profession exercise judgement on the basis of this knowledge. Cathy, however, is often frustrated by her inability to exercise judgement in this way. This inability derives from a conflict between the perceived legitimate authority of the charge nurse to control the work setting and the professional value placed on responsible, knowledge-based judgements made by registered nurses.

Cathy sees the charge nurse as a very dominant figure. According to her the charge nurse makes, or oversees, many decisions that, as a registered nurse, she herself should be making independently. During the interviews she reports that the charge nurse treats the staff nurses in the ward '***like children***', '***like students***', and '***like little babies***'. She also describes the relationship as:

C3/10/7
We've got one big chief and we're the little Indians.

Her frustration at this is illustrated in the following extracts from Interview 3.

C3/10/7
(...)<the charge nurse> ***is always on top of you. She's always overseeing everything you do. Like, one of my patients had a coated tongue the other day and I took this on myself and took a swab... I thought she might have had thrush... and I was giving her plenty to drink (...) The next day*** <the charge

> nurse> ***walked in and said "Your patient's got a coated tongue. I've told her to drink plenty." And I said to her "I sent a swab".*** <The charge nurse replied:> ***"Nobody told me anything about it." I really didn't think that it was such an important thing that the charge nurse had to be told about it because I had it under control. That's just one example.***
>
> C3/47/9
> ***We're not allowed to do that*** <make arrangements for the district nurses to visit a patient on their discharge>... ***no, we're the little Indians. We do all the work.***

Clearly Cathy feels very frustrated in her attempts at exercising her professional judgement. She states:

> C3/48/2
> ***I feel we should be given more responsibility and we are treated a bit like children.(...) I'm getting tired of it and I think we're all registered staff and we should know what we're doing and we should be left to know what we're doing.***

Reflecting on her situation Cathy is able to identify conflicting messages that she is receiving. She notes:

> C3/13/4
> (...)***personally I don't think she treats us like registered staff. She does sometimes and sometimes she doesn't.(...)sometimes she expects you to have done something whereas normally she wouldn't have wanted you to do that and she would rather have done it herself.***

On the one hand, Cathy is told by the charge nurse to exercise professional judgement. When she does this however her decisions are often overridden or she is reprimanded for not consulting the charge nurse first. This conflict is illustrated in the following extract:

> C3/12/3
> ***(...)she*** <the charge nurse> ***always tells us to take the initiative to change nursing care plans and change obs. and things and quite a few times I've changed a blood pressure to BD and then you go and look and it's back to QID again. (...) She doesn't discuss it with you. She just changes it back again.(...) You take the initiative and you get put back, you don't take the initiative sometimes and you get put back. It's horrid.***

Thus Cathy learns that she should check with the charge nurse before making decisions that she sees herself, as a professional nurse, being perfectly capable of making. She comments:

C4/9/4
(...)You just don't bother <to make decisions about reducing the frequency of observations etc> ***any more.***
and
C4/11/5
Everything I go and check with her and make sure it's bloody right.

Cathy clearly feels frustrated by the above situation. To a large extent she explains this frustration in terms of what she sees is a personal failing - shyness. She indicates that, if only she was more assertive then her relationship with the charge nurse would be different. Indeed, in the following extract from the third interview she indicates that it would be better if all nurses could be more assertive. She notes:

C3/41/1
I've never seen anybody do it <stick up for themselves when, for example, the charge nurse reprimands them unfairly>. ***I'm sure there are a few around that do it (...) but I've never done it.***
[Do you think it would be better if they did?]
Yes, I do. It'd be lovely. I wish I could do it.
(...)
If you can stand up for yourself surely you can stand for your patients' rights better to, rather than just sort of being told what to do....

Cathy, however, continues to explain her inability to act in this way as a personal failure not as a reflection of the institutionally sanctioned relations of power in stating:

C3/41/8
I'm really quite shy.

Presumably she sees most nurses as sharing her personal failing of shyness.

In the above extracts there is clear evidence of systematically distorted communication which produces conformity in the practice setting. In this case it takes the form of a double message. On the one hand, Cathy is expected to practice as a professional nurse exercising appropriate, individual, judgement on the basis of her professional knowledge. On the other hand, her interactions with the charge nurse leave her in little doubt that she must check with the charge nurse on many matters which Cathy herself considers to be matters for professional judgement well within her capabilities. Cathy is expected to respect

the authority of the charge nurse and, in her particular situation, to consult the charge nurse before making decisions, or risk censure from this legitimate authority. She is therefore unable to utilise to it's full extent the knowledge which she knows she has developed and on which she believes her practice should be based.

Cathy experiences these distortions and consequent constraints on her practice as highly frustrating. She explains her frustration, and that of other nurses, in terms of a personal failing, shyness.

It is clear that Cathy does not see her situation in relation to the broader institutional structures that support the charge nurse's authority over the staff nurse. The legitimacy of this authority is a taken-for-granted aspect of the practice setting. Present relationships and practices remain, therefore, unchallenged.

Judging acceptable workloads

A second illustration of the inherent contradictions in Cathy's desire to practice in ways that are congruent with her professional values, while at the same time conforming to institutional expectations, is provided in her descriptions of workload allocations. She describes these allocations as '***frustrating***'.

She comments:

> C2/33/1
> ***Sometimes one nurse can have... like today... one of the other nurses and I had eight patients each and the other nurse had three. (...) It's all done, and even on our charge nurse's days off the rooms are allocated (...) You don't really have much say about it.***

Cathy reports that she may be allocated a heavy patient load while at the same time she is expected to take charge of the ward on the charge nurse's days off.

> C3/7/2
> ***Oh God. It's too much really. You're running around after blooming doctors rounds and filing and you never see your patients till about 11 o'clock. It keeps you away from your patients all right. I get really depressed about that.***

Cathy is able to reflect uncritically on this situation during interviews 3 and 4. She notes:

C3/8/3
<The charge nurse says> ***"Surely if you had a heavy list and you didn't feel you were coping very well you would tell someone else to be responsible for that patient." but you know yourself being a nurse, it isn't easy to say "Look, I can't cope with this. Will you take someone off me?" (...) The charge nurse thinks you can cope with that list so you should... whereas nobody can(...) you just can't cope with it and none of us cope very well with it, but you feel... well I feel, and I know a lot of the other girls feel that they don't like giving somebody away because it's their responsibility... often they feel they should be able to cope.(...) I don't expect anyone to cope with those rooms.***

C4/12/8
You can give them <patients> ***up*** <to another nurse when you are very busy> ***but you feel really guilty... giving your patients away to somebody else (...) it just sort of... like you're admitting you can't cope (...) Which you can't anyway (...) you shouldn't admit that you can't (...) I've never met a nurse yet that would... willingly admit that she couldn't cope with them.***

Thus Cathy expresses two levels of belief. At one level she claims that she knows she often cannot, when she is allocated certain rooms and responsibilities, provide the type of care that her professional values dictate she should. Yet, the contradictory belief that she must be able to cope (after all, the charge nurse believes she can) dominates and effectively constrains her actions.

Cathy inevitably experiences a level of discomfort in holding these contradictory beliefs. She knows that, to be seen, and to see herself, as a 'good' nurse she 'must cope'. At the same time, she knows she cannot cope in a way that demonstrates the professional values she herself holds.

Should Cathy ask for help she will inevitably perceive this as a personal failure; a 'good' nurse would be able to cope with the workload allocated by the legitimate authority in the matter - the charge nurse. If the charge nurse allocates this load then she must think that it is a reasonable one. If Cathy admits that she cannot cope in such circumstances she admits that, judging by institutional standards, she is not a 'good' nurse. Yet if she conforms to the expectations of the institution and does not ask for help, she will fail to provide the standard of care that her professional values dictate she should. Thus, constrained by such

contradictory beliefs, it is inevitable that Cathy can never see herself, in these terms, as a 'good' nurse.

Although Cathy indicates that she recognises that the same contradictory beliefs are held by other nurses this does not alter in any way the interpretations she makes of her own situation. She still feels the pressure to 'cope' (or at least to be seen by others to be coping) and experiences a sense of frustration and personal failure when she knows that she cannot. Indeed, in the following extract Cathy indicates that the knowledge that other nurses experience the same pressures actually masks (conceals) the contradictory nature of these beliefs.

> C4/14/7
> [You were saying that you haven't met a nurse yet that will admit that they can't cope with a list.]
> ***It doesn't seem to be in our nature to ask if we'll do things for them all the time (...) It seems to be universal I think.***

Hence she explains as 'natural' and 'universal' the intersubjectively held beliefs about coping - that nurses cope and don't ask for help. These beliefs can be seen to be linked with the institutional values of high productivity and efficiency. So strong is the belief that a 'good' nurse is efficient and can cope with a heavy workload that nurses who challenge these beliefs and admit openly that they cannot cope risk their identity as a 'good' nurse. Cathy's personal knowledge and professional values, which link coping with quality care are therefore not seen as having a significant place in the 'real' practice setting (which is itself seen as natural and unchallengable).

Control of information

Following on from the above situations, another major theme to emerge from the interviews with Cathy is her acceptance of existing relations of power, in particular the dominance of consultants over nurses and patients. This is clearly illustrated in her acceptance as legitimate the control of certain kinds of information by these doctors. This is a taken-for-granted legitimacy and is accepted even when she sees this control being exercised in ways that she believes are detrimental to the wellbeing of patients, to her own relationships with the patients she is caring for, and that, as a consequence, reduce her ability to practice nursing effectively.

During the first interview Cathy states:

> C1/6/1
> *I really enjoy it when they* <patients> *ask questions. I think it's good. I think a lot of people are too scared and are not told a lot of things that they should be.*
> [What sort of things?]
> *Oh, the outcome of the op. and that sort of thing... we're not allowed to tell anybody, even if they ask you straight out you're not allowed to tell them.(...) we had a couple of patients ask was it cancerous, you knew damn well it was but you were told you weren't allowed to tell them.*
> [Who tells you not to tell them?]
> *The charge nurse usually. It's got to come from the doctor which I suppose is fair enough too... but if they ask you they've obviously put their trust in you.*
> [How do you handle that?]
> *Just say that you don't know - the results aren't back yet.*
> [How do you feel about that?]
> *Oh, it's terrible. You feel really guilty... like you're holding information back... the doctor knows... but there's not really a lot we can do (...) Just say you'll let them know as soon as the results come in. Often you'll say you'll go and have a look but you know you can't tell them anyway but it gives them a little bit of reassurance that you are doing something. It's still a bit unfair but... The doctors come in the next day and tell them and I think that's better. (...) the doctors are more informed about that sort of thing so I think it should really be coming from them.*

As was the case with the situations discussed in the previous section (pp.82-85) here there is clear evidence of contradictions within Cathys' personal knowledge, her professional values and the intersubjectively held understandings of the practice world. Cathy is aware of, and constrained in her actions by, the shared and accepted understanding that the doctor legitimately controls access to certain kinds of information, particularly that relating to the diagnosis of malignancies. She is very clear that she is '***not allowed***' to give this kind of information to patients should they request it even though she may have access to it herself. She sees this as legitimate explaining that '***the doctors are more informed about that sort of thing'.***

As a consequence of this understanding Cathy finds that her relationships with some patients necessarily becomes one of deceit rather than openness in that she finds herself being forced to lie about, or at least conceal from the patient, what she does in fact know. She does not analyse this in terms of the social structures which lead to what can be seen

as a breach of trust between herself and the patient. Instead, she takes on a personal responsibility for the situation and reports feeling '***guilty***' because she cannot give information to which she believes they are entitled.

While Cathy sees that it is '***unfair***' that these patients should be deprived of information in this way (personal knowledge), and that they have '***a right***' to to be given such information (professional knowledge), she views the situation as being totally outside her control. She takes-for-granted the social structures and understandings which support these practices which constrain her freedom to interact openly with patients.

Included in this is an acceptance of some doctor-centred rather than patient-centred practices. For example, 'senior' doctors (ie. those seen as being entitled to control this information) may visit the wards at times that are convenient for them, not at times which necessarily suit the needs of patients. Cathy clearly understands that these doctors should not be contacted to provide information at other times (although appointments can be made), nor are they expected to have anticipated the need for such information provision.

It also seems highly unlikely that, given her relationship with consultants, Cathy would feel able to inform the consultant that her ability to maintain an open relationship with patients is placed in jeopardy by the delay in providing appropriate information. For example, during the first interview she states:

> C1/21/8
> ***I suppose me personally - I'm a little bit shy of hierarchy and people with... up the scale, so I'd rather talk to the housesurgeon than the consultant cos I'm a little bit embarrassed talking to a consultant... and that's from me so I suppose patients... it'd be worse for patients to try and talk to a consultant(...).***

As with the her relationship with the charge nurse Cathy explains a social pattern of relationship in terms of the personal failing of 'shyness'. She notes:

> C1/22/3
> ***Oh it's just me - I'm shy around the charge nurse as well (...)***
> ***...it's stupid. I'm trying to change my way of thinking but it's quite hard.***

Cathy accepts as an inevitable 'fact' of the practice world that patients must wait for information even though she sees that this as essentially '***unfair***'. She also accepts that she herself can only conform to the accepted practice of concealing from patients information that she feels she is not entitled to disclose. At the same time she states that she feels guilty because:

> C2/23/1
> ***I don't like withholding information from people because it's their body and they're entitled to know... I'm not allowed to tell them. That's why I feel guilty. You should be able to tell them. They have a right to know.***

Cathy in the extract below describes a situation which further illustrates the way in which access to certain types of information is controlled by the doctor. It also illustrates communication that is distorted in ways that reflect and perpetuate existing relationships.

> C3/31/10
> <The consultant> ***said to him*** <a patient> ***the other day that it's an uphill battle and we'll just have to see what happens.(...) what we all assumed from*** <that> ***was that there's nothing they're going to be able to do. They've written he's not for resus. in his notes but they haven't actually said to us "Look he's terminal." It was a very vague thing we got from the nurse that went around with*** <the consultant>... ***she said that all he had said was that it's an uphill battle and we'll just have to see what happens, but she said she got the impression from what he said that there was no hope for him, he was terminal.***

Here communication is distorted. Cathy and the other nurses understand that the patient is '***terminal***'. They are not however told directly that the doctor believes that this is the case.

The doctor is assumed to be the only person who can legitimately judge whether or not the patient is dying. The doctors' definition of the situation is the one that matters most. That Cathy accepts this is particularly clear in the following extract from earlier in the third interview.

> C3/19/7
> <There is a man in the ward with> ***hepatic duct Ca and he's just given up, he's sitting there, but as*** <the consultant> ***said, there's no physical reason to give up so we're pushing him to get better. (...) Well, his wife wants him home. I think we should get him home. Which is a bit unfair on him because he just wants to sit there and die but then he can live and I think we should do everything we can to help him live. That's what we're here for.***

While nurses (and presumably patients) may 'know' that the patient is dying they remain uncertain until the legitimate authority, the doctor, confirms it. The doctor is also seen to legitimately control this information and, as the most appropriate judge of how much others should be told, is not obliged to share it.

Cathy, although she 'knows' that the patient referred to in extract C3/31/10 above is dying, is unsure as to just what the patient himself understands from the interaction with the doctor. When asked about this Cathy explains that the other nurse has told her that '***...she thinks he knows...***'.
The relationship between the nurse and patient is thereby constrained for, as indicated above, Cathy knows that she must tread carefully when she is not sure what the patient knows for fear of touching on information that is the legitimate domain of the doctor.

Given this overall climate of distorted communication and lack of openness it does not seem surprising that Cathy reports that, although she is uncomfortable withholding information she also feels personally uncomfortable handling dying patients and talking about death. She comments:

> C3/17/10
> ***With me personally, I find it very difficult to talk to people about death. And cancer, it usually leads to death and when they've got that sort of cancer and they're not told about it it's usually inoperable and I just find it very hard to bring the subject up anyway.***

Although she states that she has nursed many people with cancer who are dying Cathy states that she has not talked to them about death.

> C3/18/6
> ***Nobody's ever talked to me about it*** <dying>. ***Nobody's brought the subject up. They probably sense... I can't remember actually changing the subject if somebody had brought it up or anything.***

Cathy reports discussing the topic '***death and dying***' with other nurses and realising that they too were uncomfortable with this aspect of nursing. She notes:

C3/18/5
I thought everybody knew <how to handle death and dying> ***and I was a bit hopeless but since I (...) sort of talked to some of the nurses in our ward and even, there's one that's been through quite a long time and I sort of talked to her about it and I thought she would be really good but she said she still can't cope with it.***

In these extracts Cathy finds a personal explanation for the difficulties she experiences in relation to dying patients. Although she accepts that other nurses share her discomfort she does not move beyond the personal level of explanation to examine the intersubjectively shared beliefs and the socially determined constraints described above that contribute to her discomfort and that of the other nurses.

In particular, she does not recognise the possibility that much of her discomfort may derive from the contradictions evident between her personal knowledge and professional values (wherein she believes that patients have a right to know about their condition and that she has an obligation to assist them to handle any potentially disturbing information) and the shared ideologically based beliefs about the doctors' legitimate control over particular kinds of information. Thus, existing practices are seen to be outside her control and existing relationships are perpetuated.

FINAL INTERVIEW

The final interview with Cathy lasted approximately one and three quarter hours. During this time the draft of the previous sections of this chapter was discussed with her.

Cathy confirmed the accuracy of, and expanded on much of what was reported in the chapter. Of the interpretation she said:

You've captured it really well.

She did however note that her reported comments on p.82 that:

...the charge nurse treats the staff nurses 'like children', 'like students', and 'like little babies'

were '***perhaps a little strong***'. Nevertheless, she reaffirmed that the analysis of the effects on her ability to act (pp.) was accurate. She also stated:

> ***You've caught the charge nurse better than I could have***

and reported that she believed that her actions and interactions in the ward area which she had since moved to were still affected by her experiences. For example:

> ***I find myself asking*** <the new charge nurse> ***different questions, just checking with her about things she probably thinks are stupid because they're obviously my decision to make but I check with her first because that's what I've had to do to get along with the one before.***

While in reflecting on her experiences and in discussion of the analysis Cathy was apparently able to recognise the constraints on her abilities to exercise personal and professional agency she continued to see these as inevitable and beyond challenge. This is illustrated in the following extract in which, when asked about the interview experience Cathy replied:

> ***It was good, made me think about some things.***
> [Has it changed anything?]
> ***It's made me a bit more aware.***
> [Have you been able to move from that to change anything?]
> ***Not in that ward.***
> [Did it make you more frustrated?]
> ***No, you just accepted it there, you just had to accept what was going on, you couldn't do anything.***

CHAPTER EIGHT

'BETH'

PROFILE

Beth is a woman in her twenties who graduated from a hospital based programme as a Registered General and Obstetric Nurse more than two years prior to the first interview. Her education leading to this registration had been undertaken at the same large regional hospital at which she was working as a staff nurse at the time of the study.

In the intervening period between her graduation and the first interview Beth had worked as a nurse for less than twelve months. She travelled for the remainder of that time. When the interviews began she had been working for two months in an acute care (surgical) ward.

SYNOPSIS

Social institutions are often structured around relations of power that are so firmly embedded that those who participate in them do not perceive that they could be otherwise. These relationships are expressed in a variety of social practices and perpetuated by shared understandings (ideologies) that may not stand up to critical analysis.

Ideological beliefs and social relationships and practices may contain contradictions which cannot be logically reconciled. Such contradictions, between personal knowledge, intersubjectively shared understandings and social practices, are evident in Beths' descriptions and interpretations of some of the practices within the setting in which she works.

Beths' description of the way that doctors' rounds are conducted and her interpretation of these events provides examples of such contradictions. She describes doctors' rounds as '***horrible things***' and observes that she does not like the way that patients are treated in the process. She claims that she '***cannot understand***' why doctors would treat the patients in this way.

In making such a claim Beth indicates that she cannot adequately reconcile her personal knowledge (she knows that she herself would not wish to be treated in this fashion), her professional values, and the overtly claimed values of the institution, with the actual practices that she observes. She attempts to do so by viewing her personal knowledge as simply applicable to herself - '***lay people***' must experience these situations differently (although at the same time she acknowledges that they cannot). She concludes that patients just accept it as a natural part of being in hospital, as she herself appears to do. (pp.98-99)

Beths' observation that patients do not appear to react unfavourably to situations which she knows that she herself would find uncomfortable is taken at face value. She does not link her observations with any analysis of the wider power relations within the institution. Yet earlier she had demonstrated an understanding of the negative effects such relationships may have on patients in other situations. In particular she comments on the way in which patients may be inhibited in their interactions with medical personnel and may be unable to ask doctors questions or question their actions. (pp.99-100)

Beth also does not use this recognition of the effects of institutional power relationships in her interpretation of other situations. For example, she expresses frustration when patients ask her questions or provide her with information that she believes is more appropriately directed to medical staff. She treats this as though it was simply a personal problem for patients and expects them to overcome their inhibitions with medical staff. Yet similar difficulties are evident in her own interactions with doctors. (pp.100-101)

Beth indicates that doctors' rounds may also be greatly disruptive to nursing staff in their interactions with patients. It is the perceived 'naturalness' of the status quo and of the authority of doctors and the charge nurse and that leads her to conform with such practices.

The charge nurse conveys the message that '***It's a big crime-of-the-century***' if patients are not on their beds in time for the doctors to see them. She indicates that the doctors will be upset and won't look at the patients unless they are.

Consequently Beth understands that nurses and patients must organise their schedules so as to accommodate the doctors' routine. She also knows that she must not do anything that

will upset the doctor. The authority of the doctor is therefore reinforced by the charge nurse, and by social practices which are oriented towards meeting the doctors' (and possibly the charge nurses') needs rather than those of other social actors. (pp.101-102)

There are other indications that Beth respects the authority of doctors and the charge nurse and is therefore tolerant of behaviour that would, if she were to exhibit it herself, be seen as unacceptable. For example, when Beth is '***in charge***' on a shift she is expected to know about all the patients in the ward. If she is unable to provide the consultant with information when he requests it she indicates that she is made to feel '***stupid***'. Consultants, on the other hand, are not expected to know the patients under their care and one particular consultant who does not even remember the patients who he has operated on is said to be '***a laugh***'.

Beth also accepts that consultants and the charge nurse can reprimand her for things that are not her '***fault***'. While she recognises that this is essentially '***unfair***' she diminishes her personal experience by explaining that, for example, the charge nurse '***needs a scapegoat***', and that this pattern is a natural part of any work setting anyway. Thus, such experiences are a taken-for-granted part of Beths' practice world and existing relationships reaffirmed and perpetuated in everyday practices. (pp.102-104)

The belief in the legitimacy of existing power relationships that Beth shares with other social actors at times influences the extent to which she is able to act in ways that express her knowledge-based, professional judgement. For example, Beth describes a situation in which a doctor would not come to see a patient when, in her opinion, he should have done so. Beth was unable to challenge the doctors' authority and therefore was unable to act in what she believed to be the patients' best interests. Thus, in the face of an ideological belief in the legitimate authority of the doctor Beths' own knowledge and professional judgement was denied expression.

Beth provides personal explanations for the frustration that she experienced in response to this situation. She explains that it was her '***fault***' and the doctors' '***fault***' that this situation had occurred. Explanations such as these are only partial. They serve to mask inherent contradictions in respect of the ideological beliefs that she shares with other social actors, her personal and professional knowledge, and the social practices she observes. Beth does

not, therefore see that the source of her frustration may actually lie in the generally accepted institutional relations of power. She also does not recognise that these relationships are socially negotiated, not a natural and inevitable part of any practice setting. (pp.104-106)

A further example of the way in which Beths' ability to act may be compromised by her acceptance of existing power relationships as inevitable is provided in her descriptions of the way in which she interacts with the ward charge nurse. Beth sees that the authority of the charge nurse must be respected, and that she and other nurses must conform to the charge nurses' instructions even they disagree with them.

Beth and other staff nurses, for example, complete peer performance appraisals even though they see no point in them and find them threatening. This reluctance derives from the belief that it is the charge nurse who is the most appropriate person to judge staff nurse performance.

Beth sees performance appraisals in largely negative terms - as a means to determine '***what you are not doing***' from the point of view of another person. She does not recognise the alternative possibility that they may become a cooperative means to affirm and improve standards of practice.

This view is reflective of a setting in which there are hierarchically organised relations of power. These relationships are, as indicated above, constituted and legitimated by the ideology of the institution, by the shared understanding that there is a legitimate basis for particular social actors to have authority and power over others.

Performance appraisals completed by the charge nurse are one means by which Beth and other nurses come to know the boundaries and legitimacy of authority. Peer performance appraisals are seen to be '***threatening***' because they potentially challenge the taken-for-granted institutional structure which depends on cooperation with peers, but direction and '***discipline***' from above.
(pp.106-110)

EXTENDED COMMENTARY AND INTERVIEW DATA

Contradictory Practices and Beliefs

Social institutions are often structured around relations of power that are so firmly embedded that those who participate in them do not perceive that they could be otherwise. These relationships are expressed in a variety of social practices and perpetuated in shared understandings (ideologies) that may not stand up to truly critical analysis.

Ideological beliefs (which serve to perpetuate and justify existing conditions) and social relationships and practices may contain contradictions which cannot be logically reconciled. Such contradictions - between personal knowledge, intersubjectively shared understandings and social practices - are evident in Beths' descriptions and interpretations of some of the practices within the setting in which she works.

Doctors' rounds

For example, during the first interview Beth described doctors' rounds as '***horrible things***' and the regular morning each week when three consultants, their registrars and housesurgeons go around every patient as '***the most horrific morning***'. She notes:

> B1/12/1
> ***I think it's a real... such a horrible thing to do. I can't understand that doctors would... (...) they just all go round and they poke people and look at wounds and talk over them and say what they've done and the patient virtually isn't really spoken to except saying 'good-morning' type of thing.***

In the second interview Beth she states:

> B2/20/5
> ***They've done that for years (...) I remember when I was a student we had this big doctors' round once a week (...) it's just a procedure that they've done for... and they all do it.***
> <Doctors' rounds are> ***not very nice... I mean, if I was a patient and I had all these doctors... I suppose for me it's different. A lay person doesn't - they don't seem to mind it. I mean, they must do but they don't say anything.***
> ***(...)***
> ***I suppose they just accept it as a hospital...(...) I think they just accept it (...) because we know it's happening and... they're always kind of*** <asking> ***"Oh, when is the doctor coming?" so I suppose we say "Oh*** <specifies day> ***and (...) there'll be three consultants plus... there'll be quite a few of***

them". (...) a lot of the time they get discharged and things like that, so they probably think it's fine.

Beth, in claiming that she '***cannot understand***' why the doctors would behave in this fashion, indicates that these social practices contradict her personal knowledge (she knows that she herself would not wish to be treated in this fashion), and her professional values (including the notion that care should be patient centred and that patients should be treated with respect). These values are presumably similar to the values overtly claimed for the institutions and by other institutional members (including doctors).

Beth cannot adequately reconcile her personal knowledge, her professional values and the overtly claimed values of the institution, with the actual practices she observes. She attempts to do so by viewing her personal knowledge as simply applicable to herself - '***lay people***' must experience these situations differently (although at the same time she acknowledges that they cannot) - and she concludes that patients must simply accept it as a natural part of being in hospital (as she herself appears to do). Such practices are seen as a 'natural', hence unchallengable part of the work setting; after all, doctors rounds are '***just the procedure that they have done for*** <years> ***and they all do it.*** They are a taken-for-granted part of Beths' practice world.

Consent forms

Beths' observation that patients do not appear to react unfavourably to situations which she herself would find uncomfortable is taken at face value. She does not link this observation with any analysis of wider power relationships within the institution. Yet, in an earlier discussion she demonstrated an awareness of the negative effect such relationships may have on patients in other situations. This is particularly evident in the following interview extract from a discussion which was focussed on nurses being responsible for getting patients to sign '***consent for treatment***' forms.

B1/9/4
I think it's an uncomfortable procedure to do because, to go in and say "Well, do you mind signing here? and kind of signing your life away really" even though you're saying afterwards that it doesn't mean anything - that if you don't want anything done <you can say so>.
(...)
...doctors to a lot of people are doctors and you never ask them questions and you never go back on what they say and

> ***think once they've signed this consent form that they've got no right to go back and say*** <no>.

Here Beth indicates that she knows that the ability of patients to act may be constrained by the power relationships and practices within the institution. She notes that the act of signing the consent form is interpreted by many patients as '***signing your life away***' even when the nurse tells them that this is not the case.

Beth knows that doctors are seen to be powerful people who legitimately determine what should be done. She is aware that patients may be inhibited in their interactions with medical staff and may be unable to ask questions of doctors or question their actions.

She does not, however, use this knowledge in interpreting other situations such as her observations of patients' reactions (or, more precisely, their apparent non-reaction) to doctors' rounds as described above. It seems that not only the practices, but the relationships that underlie them are seen as simply a 'natural', permanent, unchallengable part of the work situation.

That Beth does not use this early recognition of the effects of institutional power relationships on patients in her analysis of other situations is also evident in the following extract from interview 3. Here Beth is expressing her frustration at patients who ask her questions, or give her information, that she believes is more appropriately the domain of doctors.

> B3/20/4
> ***(...) we are saying to them*** <patients> ***"Well, ask your doctor. He doesn't bite." type of thing (...) If I know a doctor is coming round and someone's feeling sick I'll say "Well*** <the consultant> ***is coming around. Tell him." There was a lady today complaining that she was feeling sick and I said "Well*** <the consultant> ***is coming round. Tell him."***
> [Did she?]
> ***I don't know. She never complained about it when I went up there.(...) She would've said something to him I imagine because she'd been in hospital for a long time and she must be used to it.***

Beth thus treats the situation as though it was simply a personal problem for the patient. She <u>expects</u> the patient to overcome her inhibitions, to tell the consultant about her

problems and ask questions, particularly because she has been in hospital for a length of time and should be '***used to it***'. Beth does not however acknowledge the part played by the institutionally structured relationships and practices in contributing to the patients' reluctance to act in this way. Yet similar constraints on her own agency are evident in the extracts discussed below.

Passivity (and frustration) in the face of perceived legitimate authority

Beth not only sees doctors' rounds as potentially problematic for patients - she also acknowledges that they can be greatly disruptive to nurses in their interactions with patients. It is, however, what she perceives to be the legitimate authority of others (ie doctors and the charge nurse) that leads her to conform with such practices.

This acceptance of the authority of others is evident in the following extract from interview 1. Here she is describing the morning each week on which several consultants do their 'ward rounds' together.

> B1/12//3
> ***...it's a horrible morning cos you can't do anything because if your patient's not on the bed then you're just about hung so you can't kind of get people up...***

This was discussed again during the second interview when she notes:

> B2/19/6
> ***(...)you can never move the patients from their bed because all the consultants are coming and they have to be lying on their bed (...) because if they're not on the bed they won't look at them (...) they're on their beds or it's a big 'crime-of-the-century'(...)***

Beth reports that it is the charge nurse who gives her the message that it is a '***crime***' not to have the patients on their beds. Clearly Beth believes that the charge nurse herself has received the same message. She comments:

> B2/20/4
> <The charge nurse has> ***had it in the neck that this patients' not on their bed (...) it's such a stupid time to come around because everyone's had their breakfast so everyone wants to have a wash. It's such an inconvenient time.***

Thus the charge nurse conveys the message that consultants will be upset and won't look at the patients unless they are on their bed. Consequently Beth understands that nurses and

patients must organise their schedules so as to accommodate the doctors' routine even though she knows that there would be other, more convenient (for nurse and patient rather than the doctor) times for them to visit. Beths' personal knowledge of the work setting is therefore denied in the face of overriding ideologically-based shared beliefs about the legitimacy of doctor-oriented practices.

Beth also understands from the messages of the charge nurse that doctors are allowed to get upset and refuse to see patients when other social actors do not automatically conform to their wishes. The perceived legitimate authority of the doctor is therefore reinforced by the charge nurse, and by social practices which are orientated towards meeting the doctors' (and possibly the charge nurses') needs rather than those of other social actors.

There are other indications that Beth respects the legitimate authority of the doctor and charge nurse and consequently is tolerant of behaviour that would, if she were to exhibit it herself, be seen to be unacceptable. For example, when Beth is 'in charge' on a shift she is expected to know about all the patients in the ward irrespective of whether or not she has worked on previous days or ever looked after them. Doctors on the other hand are <u>not expected</u> to know about the patients under their care. This difference is clearly illustrated in the following extract.

> B3/12/5
> <Being in charge and going on doctors' rounds is> ***alright. I mean, as long as you know your patients... what the ward's generally got and what they're up to and what they've had.***
> [And do you?]
> ***Generally. Like today it was more difficult because we'd had about ten acute admissions over the weekend... and it's hard because*** <the consultant> ***doesn't know any of them (...) he doesn't even remember half the time the patients that he's taken to theatre so he's never going to know who these other ones are. Plus the registrar and his housesurgeon weren't on over the weekend so you just tell them virtually what they've come in with and what they've had.***
> ***(...)***
> <This particular consultant> ***he's good though. He's a laugh actually. He never knows his patients... "Tell me what I did to him again?"***
> [Did you know most of the patients?]
> ***Yes, because I'd been on over the weekend but if I hadn't it would have been a different story (...)***
> [If you hadn't known them how would you have felt.]
> ***Not very confident... but you muddle along a bit... you basically know from our report.***

Thus it can be seen that Beth is expected, and expects herself, to be able to inform doctors of what has been happening with all the patients in the ward. If she does not know about them she does not feel '***very confident***'. On the other hand when the consultant does not remember even the patients who he has operated on this is accepted and he is seen as '***a laugh***'. Specific knowledge of individual patients is, it seems, expected of nurses but not consultants.

Beths' experience of being '***in charge***' and accompanying doctors on their rounds was further explored during interview 4.

> B4/37/5
> [You like to give the impression that you do know <about patients>?]
> ***Oh, yes. It's nice to say "Oh yes, well he ordered that test" and "No, we haven't got the results." If I don't know*** <about test results> ***I'll just say "I don't know if they're there or not" but, like, things like whether their bowels have moved and things like that's a bit kind of...*** <I say> ***"Well I think so."***
> [Do you feel a bit uncomfortable...?]
> ***Not knowing. Yes. Things like if redivac bottles have been changed if they haven't been written down and things like that.(...) You feel a bit stupid even though it's not your fault*** <that you don't know.>
> [Do the consultants give you that impression?]
> ***Yes, some of them do... that you're stupid... that's a reason why I wouldn't want to be a charge nurse... if things aren't done but it's not your fault but you're the one that's getting it in the neck really.***
> [That's not particularly fair is it?]
> ***No it's not but they*** <the consultants> ***don't really care do they. As long as they've got someone to kick they don't really care who it is...***
> [Is it strange that we <nurses> let them get away with that?]
> ***I suppose it's just ... once it's done it's done and you forget about it.***

Beth is in a state of uncertainty when she is accompanying doctors on their rounds. She knows that there may be questions asked of her that she cannot answer. She also knows that the consultant may make her 'feel stupid' or reprimand her for things that are not her '***fault***'. Although she is able to recognise that this is essentially unfair she nevertheless accepts it as inevitable and beyond challenge. She implies that it is of little significance and that '***once it's done you forget about it.***' This is reflective of ideological beliefs about the

legitimacy of medical dominance and authority - doctors are in authority and are therefore allowed to be '***unfair***'.

Beth also notes that the charge nurse at times reprimands her for things that are not her fault. Again she accepts this without challenge even though she agrees that it is essentially unfair.

> B4/39/9
> ***... it's just something that you... I suppose you think "Oh well that's... it's nothing major" type thing (...) if it's just a a little minor thing you think "Oh, well, she's got to have someone to say... she might as well say it to me".*** <So you become> ***the scapegoat.(...) it's just the way it goes I suppose. But then you must get*** <the same thing> ***in any job.(...) It's just probably annoying for half an hour and after that you probably... think "Oh yeah...".***

Again this extract illustrates and reflects the existence of a general understanding that those in legitimate authority do not have to act fairly with respect to those 'beneath' them. Beth, does not challenge the authority figure in such circumstances and diminishes her personal experiences by explaining that the charge nurse needs a scapegoat and this pattern is a normal part of work settings anyway. Thus, the experience is taken-for-granted and existing relations of power are reaffirmed and perpetuated in every day practices.

Professional judgement overridden

While the general understanding that doctors are legitimately in authority over nurses, and charge nurses over staff nurses, is communicated and perpetuated in every day practices it also has implications beyond situations such as those described above. In particular it at times influences the extent to which nurses are able to act in ways that express their professional judgement.

Beths' acceptance of the social relationships wherein the doctor has authority over the nurse, and the consequent frustration of her professional judgement, is clearly illustrated in the following extract. Here Beth describes a situation in which she was unable to get a doctor to come up to the ward and see a patient when, in her professional opinion, he should have done so.

B4/47/8
I was really slacked off with this doctor that... even though I'd rung him about three times in the night just wouldn't <come to the ward to see a patient> ***that I didn't think was very well... There wasn't much I could do because I can't really say*** <anything>. ***He just kind of hung up on me.***
[You didn't feel you could say to him that that was unacceptable and that you needed him to <come up>.
Well, he's just... he was the kind (...) that wouldn't have cared anyway, that would have just said "Well, that's the way it is" type of thing (...) I said to him to start off with "Look, I'm really worried about her." and he just said "Oh, all her signs sound fine" and, like, her obs were alright. There was nothing really to say that... she just didn't look right...
[You weren't happy with her?]
No, but he was kind of happy with all her obs.(...) there was nothing really major wrong with her but she needed a bit more fluid that he should have come out and <charted>.
(...)you still feel that it's your fault, even though it's not your fault... it is the housesurgeons' fault but you feel like maybe I could have said to him "Come out and see her." but... you can't really.

Thus Beths' own knowledge base and professional judgement is denied in the face of the legitimate authority of the housesurgeon. She cannot find a way to act on her knowledge and is reliant on the housesurgeons' judgement, his respect of her judgement and/or her own ability to convince him that he should do as she what she asks. When in this case none of these result in the doctor coming to the ward to see the patient Beth finds there is no way that she can effectively challenge his authority or act in what she believes to be the patients' best interests.

Beth provides a personal explanation for the above situation. At one level she says she feels that it is her '***fault***' presumably because she has been unable to act in what she believes to be the patients' best interests in persuading the housesurgeon to come to the ward. At another level she recognises that her actions were constrained but she again explains this in personal terms - ie. it is the ***particular*** housesurgeon who is at fault.

Personal explanations such as those provided by Beth serve to mask the contradictions evident at a wider level of analysis. In particular Beth does not see that the source of her frustration may ultimately lie in the institutionally sanctioned relations of power.

While she implicitly gives recognition to the notion that, in this situation, the attitude of the housesurgeon has prevented her acting in accord with her professional knowledge and

beliefs, Beth does not look beyond this individual doctors' behaviour. She does not see that the belief in the unchallengability of doctors' authority shared by the various social actors contributes to her frustration. She also does not surface the contradictory nature of the simultaneous expectation that she will exercise appropriate professional judgement while at the same time that judgement is not valued and she is prevented from acting on it. Thus, individual analysis masks the influence of socially determined relations of power, relationships that are not of themselves 'natural' and inevitable.

Performance Appraisals

Beth sees that the legitimate authority of the charge nurse allows her to instruct staff nurses to do things that they do not wish to do, feel threatened by, and/or that they can see no point in. Beth feels that she is not in a position to effectively challenge this authority even when she and other nurses disagree with the instruction. This was made clear when, at the beginning of the second interview Beth described her reaction to the introduction of peer performance appraisals (where staff nurses were expected to write a performance appraisal on one of their staff nurse colleagues). The following extracts are from that discussion and illustrate Beths' experience of the nature of the charge nurses' authority over the staff nurses in the ward which she was working.

> B2/1/3
> ***... you write down all their bad things and then*** <the charge nurse> ***goes over it with them. It's a lot of crap.(...) We had a meeting and we said we don't want to do it because being in secrecy and it can threaten people. But... you do it.***
> ***(...)***<The charge nurse> ***just said that*** <the assistant principal nurse> ***wanted to see how they worked out.***
> [Why are these evaluations done?]
> ***I think they just reckon it's a new nursing trend....***
>
> B2/4/4
> ***It just seems it's thrust upon us and said "You do it instead of the person that's organised it coming to us and saying "Do you mind doing this? This is what it's for". It's "You're doing this..."***

Beth obviously sees little point in the peer appraisals that she is being told she must complete. Indeed she views them as threatening. Nevertheless she believes that she and other nurses must conform to the wishes of the charge nurse and others with authority. Indeed, so dominant is the belief in the charge nurses' legitimate authority over staff nurses that she does not see that there is any other option.

When asked about these peer appraisals at the next interview Beth replied:

> B3/7/3
> ***Oh, we never heard any more about them... We did them but nothing really (...) I've never heard anything back from them... they've kind of faded... I don't even know if she*** <the charge nurse> ***read them.***
> ***(...)***
> ***Everyone was a bit peeved... upset (...) She said "Well you've got to do it and do it... and we've heard nothing.***
>
> B3/9/2
> ***I suppose one of these days she*** <the charge nurse> ***might get around to writing her appraisal and we might see them.***

Beths' expectation that peer appraisals would be of little or no use is, from her perspective, confirmed. Her belief that they were simply a '***new nursing trend***' with little or no meaning for the practice setting is also confirmed. The unquestioned authority of the charge nurse is, nevertheless, perpetuated.

For Beth, the authority of the charge nurse is also seen to extend to her being seen as the most appropriate person to judge staff nurse performance. This is one of the reason Beth gives for not wishing to complete the peer evaluation.

> B2/2/7
> ***We get evaluated anyway.*** <The charge nurse> ***is supposed to do us every six months(...) that's more of a learning thing, what she sees you're not doing just from the charge nurses point of view.***
>
> B2/3/8
> ***I think*** <nurses> ***don't mind the charge nurse doing them because the charge nurse is meant to... she's the person that runs the ward so should run it efficiently and no-one really minds her doing it cos she's... like staff nurses are more or less the same but the charge nurse is a little bit... not so much a part... she's meant to have responsibility.***
> [Whereas when your peers do them?]
> ***I think it's a bit threatening cos you've got to work with them so if you, say, get a bad one from someone (...) that can make working with them a bit kind of threatening(...).***

When asked whether she is aware of what the charge nurse does think of her performance Beth replied:

B3/9/4
No I don't know what she thinks of me. We get on alright but I don't know. I wonder what she does think but it doesn't really worry me. I do my work and obviously I don't get... she doesn't say "You haven't done this" and "You haven't done that" to me... so it must be alright.

Beth sees performance appraisals in largely negative terms - as a means to determine '***what you are not doing***' from the point of view of another person. She does not recognise, for example, the alternative possibility that it may become a cooperative means to affirm and improve her standard of practice.

This view is not surprising in that it is reflective of a setting in which there are hierarchically organised relations of power. These relationships are constituted and legitimated by the ideology of the institution, by the shared understanding that there is a legitimate basis for certain social actors to have authority and power over others.

The charge nurse, who is seen as having '***responsibility***', is consequently also seen to be the appropriate person to make judgments of performance. Beth believes that her performance is satisfactory because the charge nurse has not told her otherwise. Formal, written charge nurse appraisals of staff nurse performance are a means by which Beth and other nurses come to know the boundaries and legitimacy of authority.

The notion that the charge nurse is the most appropriate person to judge the adequacy or otherwise of a staff nurses' performance was reiterated and further explored during the third interview.

B3/10/1
...if you've got problems, it's <the charge nurse> ***you go to really, if you want to know something. It's usually her you ask so she must know it all... the one that's asking the thick questions is obviously a bit slow in that area.***

When asked if she finds it difficult therefore to ask the charge nurse questions knowing that she will be completing her appraisal Beth replied:

B3/10/4
No, not really. If I don't know I'd rather know it. I mean it might be a stupid question but it's better than putting it off

> ***thinking "Oh well I don't know what I'm doing here" and I know it's going to sound stupid but I'd rather go and ask her and know...*** <Sometimes Beth asks other staff nurses first and> ***some of the time they don't know either... So you think "Oh well, you're not so bad after all... You won't sound as stupid if you go and ask her"*** <the charge nurse>.

Beth in the above extracts indicates that she sees the charge nurse as having knowledge that is useful for her to tap in to. Yet, she clearly believes that the charge nurse will see some of the questions that she and other nurses may wish to ask as '***stupid***'. Although she states that this does not prevent her from asking questions she at times prefers to be reassured that other staff nurses also do not know the answer before she approaches the charge nurse. Presumably this check is undertaken so that she will not be judged negatively by the charge nurse for asking questions that are '***stupid***'. This was further followed up during the fourth interview:

> B4/26/2
> <The charge nurse> ***can sometimes be a bit sarcastic if you... sometimes you think "Oh, she's going to think I'm stupid and going to say something sarcastic... like I think the new girls never used to feel that they could go to her and ask because she used to make them feel even more stupid...***

When asked if there was a feeling that staff nurses should not look stupid in front of the charge nurse Beth replied:

> B4/26/4
> ***Well, they're meant to be the boss of the ward so you must feel that they're a little bit apart from you... you've still got to have that really because... if they've got to discipline you, well it's really hard to be disciplined by someone who you feel on even levels with.***
> [So you do actually feel uncomfortable with her sometimes?]
> ***Yes. Well, you should do really because they're meant to be the boss and they're still meant to be a little bit higher than you...***
> [Is that the same with medical staff? Do you get the same feeling that they're a bit above you?]
> ***Not so much with the housesurgeons because they're only there for three weeks, so they don't know the ward either and they ask pretty stupid questions, but with registrars and consultants well yes... they are in their field and they've got... that's their knowledge.***

Charge nurse appraisals of staff nurse performance are seen as a legitimate, and necessary aspect of the practice setting. While they are ostensibly undertaken to improve the quality of each individual nurses' practice the above extracts provide evidence that they are an important means of social control, a means by which existing relations of power are constituted and perpetuated.

Beth expresses the view that the charge nurse is '***meant to be the boss***' and '***higher***' than nurses so they '***should***' feel uncomfortable with them. She sees that the charge nurse needs to be above the staff nurse in this way because '***it's hard to be disciplined by someone you feel on even levels with***'.

Thus external constraint is a taken-for-granted aspect of her practice world and appraisals are one means by which this occurs. It is not surprising then that peer appraisal was seen by Beth to be '***threatening***' since peer appraisals pose a threat to the taken for granted institutional structure which depends on cooperation with peers, but direction and '***discipline***' from above.

FINAL INTERVIEW

During the fifth and final interview the draft of the early part of this present chapter was checked with Beth. Beth indicated that in general she was satisfied with the content and interpretations made. Asked for her reaction to reading it she commented:

> <Reading it> ***at first kind of made me feel really kind of defensive in a way thinking "Do I do that?"***
> ***(...) but as you get more in to it - the structure and the hierarchy you do understand why... you feel why should it be like that but it's just the way that it is, it has been and how you've been brought up to work in the place.***

There was only one particular section in which Beth wanted clarification. This was in the section in which her difficulty getting a housesurgeon to come up to the ward to see a patient on night duty was outlined and analysed. (see pp.104-106) Here she noted:

> ***It makes it sound as if all housesurgeons are like that where it was just that housesurgeon. (...) It seems to say that most housesurgeons are like that where they're not really.***

Bet agreed however that, although this was an experience with just one housesurgeon, and not all (or indeed most) of them would act in the same way, the fact that they are able to if they so wish is never the less significant.

While she was able to reflect effectively on her experiences of practice and the practice setting Beth, like Cathy, was unable to see how the existing relationships and practices could be effectively challenged. A naturally occurring evolutionary process seems to be the only way that Beth can foresee that changes will occur.

> [Do you see any way for it to be different?]
> ***I think probably more as the older consultants leave and the younger consultants come in - it will get probably a bit more flexible but I don't really know, it's still in a fairly... the old hierarchy is there. (...)***

She does not see that she personally has any power to influence this process of change.

> [Before these interviews did you have time to think of these issues?]
> ***You do think about them but I don't think much of it because... like you always think how awful consent forms are when you're doing them and doctors' rounds - you really get annoyed with how they treat people but you don't really try and change it - it's just the way that things are, the way that you've learnt how to do things.***
>
> ***I don't feel that I can change it - I think probably because the consultants have been there so long it's the way they do things... it's the way it is.***

Thus Beth continues to see existing social conditions as 'natural' and immutable.

PART THREE

CHAPTER NINE

INTEGRATION OF DATA AND CRITIQUE

Introduction

In the previous chapter the ways in which participants understood and interpreted their social worlds were identified. In the present chapter these shared understandings are analysed and discussed with reference to the theoretical approach and concepts described in chapter 2. This discussion, supported by data from a review of nursing notes, is used to provide the basis for a critique of the way in which knowledge is currently viewed and seen to be transmitted in the social worlds in which nursing takes place.

Case study method (discussed in chapter 3) allows in-depth analysis of the single case. No person experiences or interprets any given social setting or event in exactly the same way as another. There is therefore a sense in which the descriptions and interpretations of the experiences of each of the four participants described in the previous chapters must stand on their own. Yet, precisely because we are social beings we can, and do share some aspects of our experiences and understandings with others. This is clearly evident in the data presented in the previous four chapters.

Critical social science (as discussed more fully in chapter 2) has at its core an emancipatory intent, that is, the development of knowledge that '...frees participants from outmoded and reified conceptions of reality'. Current social practices are not accepted as '...the final context of validation'. Meanings and actions are analysed '...in the light of their arrested and denied possibilities.' (Comstock in Briedo and Feinberg 1982: 374) In undertaking such an analysis with these four nurses a number of common experiences, understandings and types of interpretation of various social events and practices were evident. In particular:

i) Action constraints were experienced by each of these nurses.

ii) Contradictions were evident between participants' personal knowledge, shared intersubjective understandings, professional knowledge and values (personally held or institutionally sanctioned) and actual institutional values and practices.

iii) Participants shared at least some 'epistemic principles' ie. second order beliefs about what type of beliefs are acceptable (Geuss 1981), and used similar strategies, particularly personal explanations, in reconciling contradictory beliefs and understandings.

iv) There was evidence of reification of social relationships and practices by these nurses ie. treating existing social conditions as though they were 'natural' and unchallengable.

v) Participation of these nurses in their own domination (hegemony) was evident and

vi) There was evidence of systematically distorted communication in the maintenance of existing social relationships.

Each of these commonalities are explored below.

Constraints

As discussed in chapter 2 an important characteristic of critical social science is the explicit intertwining of social theory and social practice in the sense that knowledge is seen to be inherently linked to human interests.(Habermas 1978) Knowledge claims are thus clearly tied to '...the satisfaction of human purposes and desires.' (Fay 1975 p.95)

The emancipatory interest of critical social science finds expression in '...analyses of a social situation in terms of those features of it that can be altered in order to eliminate certain frustrations which members in it are experiencing...'. (Fay 1975: 92)

Each of the study participants was in different ways frustrated by various aspects of her experienced practice world. In particular, each was at times unable to practice in ways that effectively utilised her professional and/or personal knowledge base, and that reflected her personally held professional values.

Amy and Cathy for example, both felt constrained in their interactions with some patients because they accepted that they must not encroach on information that is considered to be the legitimate domain of the doctor. (refer pp.52-55 and pp.87-90) Amy also described situations in which she could not express her knowledge-based, professional judgement in actions seen to be in the patient's best interests because she felt unable to challenge the authority of the housesurgeon (refer pp.40-43) Cathy on the other hand found that she often could not express such judgement because she acknowledged the authority of the charge nurse as legitimate. (refer pp.81-84) In addition, both nurses were frustrated when workload constraints meant that they could not provide the standard of care that their professional values dictated they should. (refer pp.55-57 and pp.85-87)

Like Amy, Beth too found that she could not always express her knowledge-based, professional judgement in acting in the patient's best interests because she felt unable to challenge the of the authority of the doctor. (refer pp.104-106) She also described situations where she and patients felt that they must organise their schedules on order to accommodate the routines of doctors even though this was inconvenient.(refer pp.101-102) Finally, Emily felt that she was generally constrained in her interactions with consultants and noted, for example, that it was not possible for her to join in on doctors' rounds even though she believed that it was in the patients' best interests that she do so. (refer pp.67-69)

Contradictions

Critical explanations seek to

> ...reveal the contradictory consequences in social structure which result from acting in accordance with dominant meanings - consequences which render the actors' intentions unachievable in the context of changed circumstances.
>
> (Comstock 1982: 375-6)

The frustrations experienced by these four nurses were an expression of contradictions between:

i) the participants' personal knowledge (their own expectations and understandings derived from life experiences and experiences of institutional practices),

ii) their professional knowledge and values (personally held),

iii) the understandings shared with other social actors (intersubjective understandings constitutive and reflective of the dominant ideology of the institution),

iv) knowledge, values and actions overtly sanctioned by the institution) and

v) the actual institutional values and practices that these nurses observed and participated in.

What became clear in the course of the interviews was that each participant expressed and switched between these different, at times contradictory, levels of belief and understanding. Often, for example, (as illustrated above) they expressed personal and professional beliefs and understandings which contradicted understandings, shared with other social actors, which were reflective of the institutional ideology. By acting in accordance with the dominant ideological meanings they often denied expression of their own personal and professional knowledge and values.

In addition, it was clear that the knowledge, values and actions espoused in the ideology of the institution, were not always congruent with the actual values and practices that they observed. For example, these nurses were aware that at times doctor-oriented practices such as doctor's rounds acted against, rather than promoted, the patient's best interests.

Epistemic Principles

Geuss (1981: 61) notes that:

> Human agents don't merely have and acquire beliefs, they also have ways of criticising and evaluating their own beliefs. Every agent will have a set of epistemic principles ie. an at least rudimentary set of second-order beliefs about such things as to what kind of beliefs are acceptable or unacceptable.

Epistemic principles are often shared with other social actors in the form of tacit 'common sense' understandings. They set limits to the types of beliefs that an individual or group will see as acceptable. Ways will often be found to reject beliefs contradicting those that, given the person's epistemic principles, are seen as acceptable.

The four study participants shared at least some common epistemic principles. They each, at various times, found ways to reject beliefs and understandings that contradicted the intersubjectively shared understandings, that is the 'conventional wisdom', of the wider social group. Such shared understandings (deriving from and constitutive of the ideology of the institution) could therefore be seen to dominate over, for example, personal knowledge derived from observation of the participant's actual practice world.

This rejection of beliefs that were not congruent with 'conventional wisdom' was evident in the type of explanation that participants gave for many of the contradictions that could be observed in their experienced social worlds. Where such contradictions were identified the participants often provided personal explanations ie. at the level of the individual, for events and experiences thus masking any possible challenge to intersubjectively shared and accepted beliefs.

Beth (refer pp.98-99) for example, rejects her personal knowledge of the effects of 'doctors rounds' on patients by seeing this as applicable only to herself not '***lay people***' and sees patients as having a personal problem when they cannot ask questions of doctors. Emily (pp.68--70) explains some practice constraints in terms of the personal factor '***shyness***' and individual doctors' personalities. Cathy too (pp.84-85) explains her inability to act in a way that fully utilises her professional knowledge base in terms of the personal 'failing' '***shyness***' and Amy explains that she personally gets '***really easily intimidated***' by medical staff without situating her analysis consistently within a the context of wider institutional relationships.

In adhering to the principle that intersubjective understandings reflective of the institutional ideology legitimately dominate over other types of understanding these nurses, as will be discussed below (hegemony), participated in maintaining their own frustrations. Where contradictions were surfaced personal explanations proved to be a strategy that would reconcile what would otherwise be seen to be challenging to these intersubjective understandings.

Explanations at this level are partial only and discourage the critical examination of wider social relationships and practices by social actors. They serve to mask inherent contradictions and therefore perpetuate existing conditions, hence also frustrations.

Reification

Comstock (1982: 374) notes that

> Under conditions of domination, actors' understandings are historically frozen by ideologies which legitimate and attempt to perpetuate existing relations of power.

Such 'frozen' understandings mask alternative ways of viewing reality and limit possibilities for choice and action.

Social formations in which one or more groups dominate over other groups are often maintained by the reification of existing social conditions by those participating in such formations.

Reification is ...the apprehension of human phenomena as if they were beyond human agency, like laws of nature. (Mezirow 1981: 10)

In reifying social conditions social actors see that relationships, practices, and/or even their own or others' personal characteristics are natural, immutable and outside human control. As a consequence the status quo is maintained, social relationships are assumed to be fixed, and alternative ways of acting and relating are hidden from view.

As indicated above, the interest of critical social science, emancipatory interest, is in developing knowledge that frees '...participants from outmoded and reified notions of reality'.(Comstock 1982: 374) Critical theories seek to differentiate between ...invariant regularities of social action... and ideologically frozen relations of dependence that can in principle be transformed. (Habermas 1978: 310).

In other words, reified relations of dependence that may, at least in principle, be different are revealed and made explicit. In differentiating in this way possibilities for choice and action may be expanded.

The tendency to treat existing social relationships and practices as 'natural', hence unchallengable was evident in different ways in the interviews with each of the four

participants. For example, each of these nurses experienced as essentially unchallengable the domination by other social actors, particularly doctors and charge nurses. Even when they felt frustrated because they were unable to act in ways that expressed their own personal and professional knowledge and values, or act in ways that they believed to be in the patients', or their own, best interests. As discussed above, personal factors such as 'shyness' were invoked as explanations. Practice constraints such as those arising from high workloads were also seen as a 'natural' part of the inevitably imperfect practice world.

Hegemony

Hegemony (discussed more fully in chapter 2 pp.) is the form of 'coercion' experienced by social actors wherein action choices are limited by internal rather than external constraint. Relations of domination are reproduced through the participation of both dominant and subordinate groups in existing social practices.

Geuss (1981) examines the way in which social actors may suffer from this form of ***self-imposed*** coercion. He notes that:

> social institutions are not natural phenomena; they don't exist by themselves. The agents in a society impose coercive institutions on themselves by participating in them without protest, etc. Simply by acting in an apparently 'free' way according to the dictates of their world-picture, the agents reproduce relations of coercion.
>
> Geuss 1981: 60)

Reification of existing social conditions is therefore one way in which hegemonic processes exert their power. Because social actors believe that the status quo is inevitable they participate in social formations that may actually serve to frustrate the needs and desires that they would have were they truly free to surface them.

There is therefore a sense in which the constraints on action experienced by these four nurses were self-imposed. They often described situations of action as though they were free to make choices when they were constrained by their reification of the existing social conditions. They were often not free to act to the extent that they did not see it as an option to challenge existing social relationships and practices even when these contradicted their own personal and professional knowledge and values.

Beyond a simple acceptance of existing social conditions and subsequent constraints is the actual participation of these nurses in the maintenance and reproduction of the very forms of

social existence which constrain their own, and other social actor's actions. The legitimacy of existing relationships was thus maintained and communicated in everyday practices.

Systematically distorted communication

Carr & Kemmis (1983) note that:

> In recognising the importance of critique critical theory focuses its attention on forms of social life which subjugate people and deny satisfactory and interesting lives to some while serving the interests of others. (p.136)

Within hegemony this subjugation is maintained through systematic distortions in communication.

As discussed in chapter 2, Habermas argues that anticipated in any communicative act is an 'ideal speech situation' wherein there is a symmetrical distribution of chances to select and employ speech-acts, and where agreement is by the force of better argument alone not established by coercion or domination. Communication may recognised as systematically distorted where the legitimacy of the agreement could not be established should it be subjected to rational discourse ie. in an ideal speech situation.

There was clear evidence of systematic distorted communication in the reported experiences, observations and understandings of these four nurses. Subjected to rational discourse, the dominant intersubjectively shared beliefs comprising the institutional ideology would not be completely validated for, as indicated above, contradictions were numerous. In particular, practices and relationships which ostensibly serve the interests of patients can be shown in reality to act against them while serving the interests of the dominant medical profession, supported by nurses. Caught up in the business of the day-to-day practice world nurses in general fail to surface this system of distorted communication and participate in practices which maintain existing relations of domination.

Documentation

The analysis of nursing documentation, one focus point for discussion with the participants (see chapter 4, p.32), provided support for the notion that nurses, caught up in day-to-day activity, uncritically participate in practices that maintain existing social relationships. In this analysis of the charts of 28 patients particular attention was given to examining the extent to which (if any) there was documentary evidence of nurses undertaking a systematic

assessment of patients informational or educational requirements, or of planning, implementation or evaluation in relation to the provision of information/education. Little evidence was found in any of the nursing documentation of this occurring on a consistent basis.

Although there was little documentary evidence of these nursing activities occurring, all the participants stated that they were carried out. Discussion with the four participants confirmed that much nursing communication occurs by word of mouth rather than being recorded in any way in the nursing documentation. For example, during the second interview when Beth was asked how she communicates information to other nurses she replied:

> B2/15/4
> ***By telling them. Like, if on a morning shift or an afternoon shift you noticed something about one of your patients, you'll say before you go that this lady's drain's oozing heaps or... And you might write it in report but then it's better to tell them because*** <the charge nurse, who provides the formal handover to the staff on the new shift> ***is not very good with her reports. She'll go through the nursing care but she wont read what the nurse has written. (...) Her report is terrible.***

Beth also states that doctors do not ever read what is written by nurses in patients' reports. Current patient reports written by nurses are kept in a folder ('the nurses' notes') separate from the folder ('the doctors notes') in which other staff such as doctors, physiotherapists, speech therapists and occupational therapists record their observations and cares planned or carried out.

> B2/16/4
> ***(...)the nurses' notes are also kept in their*** <the doctors> ***folders but that's more the nurses' notes from the days before... as you fill up a page they're taken out of our nursing folders... It's just more of a filing place thing... to keep the notes together. It's not that the doctors are going to go through them.***

Thus there is evidence that nursing documentation is not valued highly or utilised effectively by nurses, doctors and other social actors. The low priority given to such communication potentially contributes to a fragmentation and invisibility of nursing care. It also contributes to the maintenance of existing social relationships for, as Perry (1985: 55) notes:

> ... documentation shifts the balance of power. It enables nurses to 'argue the case' on rational rather than intuitive grounds. It is, therefore,

> in the interests of the dominant groups in the health structures to maintain and perpetuate nursing's oral tradition.

Reflection and action

According to Held (1980) the process of emancipation:

> ...entails the transcendence of ... systems of distorted communication. This process, in turn, requires engaging in critical reflection and criticism. It is only through reflection that domination, in its many forms, can be unmasked.
> (p.256)

To move beyond the constraints and frustrations described above requires a level of reflectivity only transiently approached in some of these nurses' early interviews - that is, a critical reflectivity. This type of self-reflection (as described by Habermas) '...operates by bringing to consciousness unconscious determinants of action, or consciousness'. (Geuss 1981: 61) It involves being able to surface and move beyond the dominant ideology, recognising and subjecting to rational critique 'historically frozen', distorted intersubjective understandings.

At times the four participants were able to surface, if just momentarily, the ideological nature of intersubjectively shared beliefs and the contradictory expectations and consequences. More often however the overriding intersubjectively agreed understandings dominated and led them for example, to provide personal explanations for the frustrating or contradictory situations that surfaced. It seemed that it was easier to challenge their own personal and professional knowledge and values than to challenge the conventional institutional beliefs.

Geuss (1981: 61-63) rightly points out that:

> ...agents don't ***generally*** come to think that their beliefs are false if they discover that they have been 'determined' by factors of which they were unaware. (Social agent's) epistemic principles are (therefore) of central importance for the critical enterprise; the critical theory shows that a form of consciousness or world-picture is false by showing that it is reflectively unacceptable to the agents, ***given their epistemic principles.***

Where agent's epistemic principles include the notion that '...legitimizing beliefs are acceptable ***only*** if they ***could*** have been acquired in a free and uncoerced discussion...' ideology critique can operate. In these circumstances, allowing agents to see that

'...coercive institutions prevent them from ever subjecting the world-picture to free discussion' may be a key step in overcoming distorted understandings.

During the final interviews each participant was provided with an opportunity to reflect on their experience of participating in this present study (see pp.58-60, 76-77, 92-93, 110-111). They were also able to reflect on the description and analysis of the content of the previous interviews.

During their final interview two of the participants, Cathy and Beth, although they clearly indicated that they were now more aware of experiencing undesirable constraints on action, continued to see existing social conditions as natural, inevitable and unchallengable.

In contrast, Amy and Emily expressed strongly that, over the time since the first interview, they had begun to see possibilities for action that had not previously been evident. They had also begun to exercise personal and professional agency in ways that they had been unable to at the time of the earlier interviews. While these changes cannot be directly attributed to their participation in this present study, both Amy and Emily stated that they had greatly appreciated the opportunity to reflect on their experiences. They also noted that other nurses would benefit from similar opportunities if they were provided.

This present study has moved beyond the types of study that predominate in nursing research as discussed in chapter one. Many of these studies are essentially conservative in that they fail to take account of the social conditions in which nursing practice is situated. In particular they fail to give recognition to the significant systematic constraints on action produced and reproduced in the institutional context and ideology. In the next chapter (chapter ten) the findings of this present study are themselves situated in a context of action as implications for nursing practice, education and further nursing research are identified.

CHAPTER TEN

DISCUSSION AND RECOMMENDATIONS

Introduction

This study has provided the data for an interpretive critique of the way in which knowledge is viewed, transmitted and crystalised in the practice worlds experienced by registered nurses. The analysis demonstrates the way in which constraints on personal and professional agency were experienced by each of these nurses, and surfaces some of the social conditions and processes which contributed to and perpetuated these constraints. In this concluding chapter the implications of the study for nursing practice, nursing education and nursing research are discussed and recommendations made. The main limitations of the study are also identified and discussed.

The emancipatory interest of critical social science, as discussed previously (refer chapter 2), is grounded in human capacities for rational understanding (and hence rational action), reflection and self-determination. It seeks a particular form of knowledge that is aimed at freeing social actors from unrecognised, illegitimate and/or unnecessary constraint. This type of knowledge, sought in the present study, has significant implications in terms of nursing practice, nursing education and nursing research.

Implications for nursing practice and education:

Knowledge for practice

Identified in this study were some of the ways in which the social and political knowledge structures of the institution often constrained rather than facilitated the knowledge-based actions of the four nurse participants, and hence militated against effective and satisfying nursing practice. These intersubjectively shared, ideological understandings reflected and perpetuated existing relations of power within the institution.

Contradictions were clearly evident within this structure, and between it and the nurses' personal and professional knowledge base. For example, although participants were encouraged by their professional ideals to exercise professional judgement in relation to patient care, actual institutional relationships and practices prevented them from doing so.

The professional ideals of autonomy and accountability were thus denied expression in the face of a strongly hierarchical institutional organisation. It is in conditions such as these that an emancipatory interest develops.

Habermas writes that:

> ...(an emancipatory interest) can only develop to the degree to which repressive force, in the form of the normative exercise of power, presents itself permanently in structures of distorted communication - that is, to the extent that domination is institutionalised.
>
> (Habermas 1974: 22)

Such institutionalised domination and distorted communication were clearly evident in the described and interpreted experiences of these four nurses. To expose and move beyond the constraints that such power imbalances impose on nurses, and other social actors, requires a particular form of knowledge. This knowledge, 'emancipatory knowledge', is that which is derived in self reflection of a distinctive character, self-reflection that:

> ... brings to consciousness those determinants of a self-formative process of cultivation and spiritual formation [***Bildung***] which ideologically determine a contemporary praxis of action and the conception of the world... Self-reflection (that) leads to insight due to the fact that what has previously been unconscious is made conscious in a manner rich in practical consequences: analytic insights (which) intervene in life...'
>
> (Habermas 1974: 22-23)

Self-reflection of this kind thus proceeds through the reconstruction of the self-formative process, that is a reconstruction of the process by which people come to a 'know' the norms, values, expectations and overall nature of their social worlds. The ways in which shared understandings have been shaped, consciously or unconsciously by relations of domination, and thereby serve the interests of dominant groups can therefore be exposed.

Such reflection provides a basis for the transformation of repressive social conditions by surfacing the taken-for-granted, shared ideological understandings, and exposing the ways in which these mask alternative possibilities for action. Thus these understandings lose their power and opportunities to overcome unexamined and unchallenged (often unrecognised) constraints are provided.

In this study the four nurses who participated were provided with an opportunity to engage in the form of 'critical self-reflection' described above. They were able to partially surface the contradictory nature of the knowledge produced and reflected in their social worlds.

This analysis could have fed into a radical critique of the social institutions in which they practice. However, as described in the previous chapters, once contradictions were identified, participants often reverted to explanations that indicated that constraints on action, particularly knowledge-based professional practices, were viewed as simply 'unintended' consequences of an inevitably imperfect 'natural' social world. There was a tendency for participants to personalise and treat these contradictions as though they were isolated, individual aberrations. Contradictions were not then seen to be associated with, or to provide a challenge to, the ideological understandings shared with other social actors. Thus, in adhering to the dominant institutional ideology, these nurses tended to be self critical (denying or devaluing their personal and professional knowledge) and were unable to sustain a socially critical perspective.

It is not surprising that these nurses were able to only partially surface the 'social construction' rather than 'natural' character of the constraints and frustrations that they experienced. As was indicated in the previous chapter participants shared epistemic principles and accepted the legitimacy of the dominant interpretations of their social world (refer p.115-117). The established institutional knowledge structure is firmly embedded, and communicated, in the everyday social practices. Ideological hegemony is thus maintained by the internalisation of this knowledge as these nurses and other social actors participate in their taken-for-granted, everyday activities and relationships.

It was also noted in the previous chapter that people are likely to resist alternative interpretations unless these understandings can be shown to be reflectively unsound in the light of the person's own epistemic principles. Allowing agents to see that they are prevented from subjecting shared understandings to free discussion may be a key step in overcoming distorted understandings.

The institutional structure of the hospital experienced by these nurses is such that it provides limited opportunities or encouragement for nurses and other social actors to stand back from, and critically scrutinise their everyday practice world. When they do reflect on their practice it is without any critical consideration of social and political elements of this

world; it is individual, isolated practice events that are scrutinised in a personally critical way. Performance appraisals, for example, (refer pp.106-108) encourage nurses to focus on their own personal 'failings' and in doing so act as an external means of control that encourages conformity. The actual social system and practices are not similarly subjected to critical scrutiny. This failure acts to support and maintain existing relations of power and diminishes possibilities for nurses and other social actors to exercise personal and/or professional agency.

In chapter 2 (refer p.11-12) it was noted that one view of knowledge is that it is the product of the contemplation of interchangeable individuals in isolation from the historical/socio-political context. Knowledge therefore comes to be treated as itself an 'object', not as a product of social negotiation, and consequently dominant modes of thought may be seen as the only possible modes of thought.

This study has demonstrated that the way that nurses and other social actors come to 'know' and interpret their social worlds is dependent on the particular historical/socio-political context in which that knowledge is produced. Yet it has also shown how this knowledge may be treated as though it were 'an object', isolated from a particular context and in this way alternative meanings, understandings and actions are masked. In other words, shared understandings may be 'historically frozen' and thereby prevent examination of new possibilities for understanding and action in the light of altered contexts, and/or alternative, equally valid interpretations within the same context.

In educational and practice settings the notion of knowledge as an object may be communicated in various ways. In particular, it is communicated where rule oriented, bureaucratic structures with clearly delineated lines of authority exist; where knowledge is seen as being 'handed down' from the person who 'knows' (the 'educator' and/or 'expert' nurse) to the recipient of knowledge (the student or 'junior' staff nurse who is seen to be deficient with regard to this knowledge); and where externally imposed evaluation encourages students and nurses to be self-critical not socially critically and self-reflective. Treating knowledge in this way contributes to the fragmentation between nursing education and nursing service, between 'theory' and 'practice'. It militates against the development of socially critical self-reflection.

Although this study did provide the opportunity for the participants to reflect on their experienced social worlds in a more socially critical way, the effect of this was to some

extent limited by the relatively isolated nature of their reflection. This isolation was in terms of both:

a) access to free and uncoerced dialogue with other nurses, and with other social actors and

b) continuity in the reflective process itself ie. reflecting in this way was not a significant part of their experienced educational and practice worlds.

If nurses are to develop through socially critical self-reflection the 'emancipatory' knowledge that will expose, and move them beyond constraints such as those experienced by the four nurses participating in this study, then reflection must become an integral and shared component of the nursing world rather than an isolated, external event. What are required are the conditions that provide opportunities for nurses to come together to engage in dialogue that may allow the understandings which they share to be affirmed, reshaped or reformulated. For example, nursing scholars may provide philosophical frameworks from which alternative understandings may be developed in critical dialogue.

In isolation from the contribution of others nurses, even where they are able to surface the contradictory nature of some shared institutional 'knowledge' individual nurses are likely to feel out of step with other social actors and revert to a personal, psychological interpretation of their understandings. They are also likely to feel powerless to change the practice world for, while they may view the world differently in that they have surfaced inherent contradictions, their actions may be undermined by the conformity of others. Transformative action in isolation is difficult to sustain.

Socially critical reflectivity must be accepted as an integral and ongoing component of the nursing world. Isolated in time and space from other experiences it loses its transformative power.

Establishing the conditions which support rather than exclude the development and sustenance of socially critical self-reflective, rather than self-critical practitioners in nursing is undoubtedly important if the types of constraint identified in this study are to be overcome. What then are the conditions required for such transformation?

There is a clear need for a closer interweaving of nursing 'education' and 'practice'. Dialogue between nurses must transcend existing boundaries between 'practitioners', 'educators' and 'scholars'. The fragmentation of nursing, wherein educational settings are seen as preparing students to practice rather than through the experience of practice, and where practitioners are seen to be largely isolated from the process of education, reflects a 'decontextualised' view of knowledge. This perpetuates existing conditions that militate against critically self-reflective practice. This is not a call for a return to the 'apprenticeship' system of education, simply an acknowledgement that nursing knowledge is constructed in human activity, not simply passively transmitted from one generation of nurses to the next.

The seeds of socially critical self-reflection should be sown early in nursing education and continuously supported in educational and practice settings. As Allen, Benner & Diekelmann (1986) note:

> What is essential about experience in nursing education is that students learn to analyse the sources of their own interpretations, to question and resist the predefined meanings we educators encourage them to adopt, and to develop the tools to negotiate a world of nursing in which the twin goals of autonomy and responsibility are achievable. (p.36)

All nurses should be sensitised to the social and political aspects of the experienced nursing world. Opportunities need to be consistently provided therefore for them to come together and critically reflect on their lived experiences both within educational and practice settings.

Educational and practice institutions should themselves be supportive of reflective practice. In settings supportive of this form of reflectivity the prevailing knowledge structure, the central values, principles and purposes of the institution, are all open to critical scrutiny. Such institutions are tolerant of diversity and open to challenge and change. As Schön (1983) notes:

> An institution congenial to reflective practice would require a learning system within which individuals could surface conflicts and dilemmas and subject them to productive public inquiry, a learning system conducive to the continual criticism and restructuring of organisational principles and values. (p.335-6)
>
> ...a reflective institution must place high priority on flexible procedures, differentiated responses, qualitative appreciation of complex process, and decentralized responsibility for judgement and action.
>
> (Schön 1983: 338)

Reflection of this kind should not be viewed in negative terms as a direct attack on existing structures. What is required is the opportunity to subject the status quo to rational, public critique in order to surface, reformulate and move beyond historically frozen or distorted understandings. Effective and satisfying nursing practice is dependent on the development of emancipatory knowledge, knowledge developed in socially critical self-reflection.

Limitations of this study

This study has identified some of the ways in which the institutional knowledge structure and processes of knowledge transmission may constrain the personal and professional action of nurses and other social actors. In doing so it speaks directly to the practice world of nurses, providing a basis for critique and transformation of that world. There are however some limitations to the study.

Firstly, the study is limited by the artificial boundaries which are, of necessity, imposed in a study such as this. These imposed boundaries are in terms of time (affecting the depth, continuity and length of observation), numbers of participants, and extent of data sources used.

As discussed in chapter 3, it is acknowledged that there are no clear limits or end-point to the reflexive process commenced in case studies carried out within a critical perspective. The process of self-reflection potentially continues beyond the actual interview times, beyond the participants directly involved in the research, and beyond the artificial end-point imposed on the study. This is both a strength and potential limitation of the chosen methodology. Written material such as this thesis can only hope to capture and 'freeze' in time a small part of a much wider, ongoing process. However, in 'sparking off' this ongoing process of reflection, the research is directly linked, indeed emmeshed in, the practice world of nurses.

Time limits can not be clearly imposed on the reflexive process. It is also not possible to predict when change is likely to occur. The spacing of the first four interviews with each participant and the final interviews occurring some time afterwards did provide some opportunity to examine change over time. There was, however, no way to determine the extent to which changes were related to the reflexive process that occurred during, and as a result of participation in the study. Nevertheless, in their final interviews the participants did

indicate in various ways that the opportunity to reflect on their experiences of the practice world had been valuable. They also indicated that they would otherwise have had little opportunity to reflect in this way.

The final way in which artificial boundaries were, of necessity, imposed was in the number and variety of data sources used. The participation in the study of only four nurses, working in a limited number and type of contexts, might be seen to be a limiting factor. However, it is not proposed that the findings can be directly generalised to other situations, nor that all, or indeed any other nurses, experience their practice worlds in precisely the same way as these four individual nurses. What is proposed is that readers are provided with the opportunity to utilise their own tacit understandings in reflecting on the description and interpretation of the experiences of these four nurses and thus illuminate aspects of their own experiences ie. to make 'naturalistic generalisations'. (Stake 1978)

Other than through an examination of nursing documentation and informal observation while collecting these data, the context was not examined independently of the participants. To do this would, however, have been outside the scope of this present study in that its focus was on the way in which the context was actually experienced by these four nurses.

A second limitation that may be identified is that the genesis of the institutional power relationships, hence many of the constraints and frustrations experienced by these four nurses, was not fully explored in this study. In order to do this a full examination of the historical context of nursing for example, the way in which gender (with nursing as historically a predominantly female grouping and medicine predominantly male) and class relationships have contributed to the development of existing social conditions would be required. Such an analysis, although beyond the scope of this particular study provides a basis for further development of this research.

Thirdly, the material presented in this thesis and the actual discussions from which it is drawn were, as is the case with all forms of research, is necessarily selective. Because of the theoretical approach there is a tendency to focus on the apparently negative aspects of the practice setting (ie. constraints and frustrations). Surfacing these aspects can however be seen in more positive terms, as potentially increasing autonomy of social actors and facilitating movement beyond these constraints. Studies which explore more fully the ways in which nurses do exercise agency, for example Benner (1984) Patterson (1988) and Bassett-Smith (1988) are complementary and provide a necessary balance.

Research Implications

The socially critical perspective from which this study was undertaken holds tremendous promise in the development of nursing practice through research. Research identifying knowledge domains encompassed in nursing practice, for example Benner (1984) Patterson (1988) and Bassett-Smith (1988), is important. However, studies such as the present one, which illuminate the social and political constraints on nursing action, are also necessary if nursing practice is to be enhanced. Such studies provide a basis for dialogic consciousness and transformative action.

Further dimensions would also be provided by broader examination of the historical context of nursing. In particular, historical studies tracing the origins of existing social relationships, shared understandings and practices would contribute more clearly an appreciation of the historical antecedents of the experienced social worlds of nursing.

There is a place for studies which provide opportunities for shared socially critical self-reflection both between nurses and between nurses and other social actors. In the interviews with the four nurses participating in this study it was possible to identify some awareness that socially generated constraints on action were also experienced by other social actors, in particular patients, nursing students and 'junior' doctors. Studies with a broader focus including a more general consideration of the perspectives of these and other social actors (including nurse educators and administrators) may demonstrate more clearly that similar constraints on action are experienced at all levels and that ideological hegemony is maintained at the expense of numerous possibilities for personal and professional autonomy.

The failure to take into account the historical and political context of nursing practice perhaps provides some explanation to the observation that much nursing research has not had a significant impact on actual nursing practice (Hunt 1987). There has been a tendency to decontextualise knowledge derived in research and thus to isolate it from the practice worlds experienced by nurses. Research of the type undertaken in this study is directed towards overcoming this gap. There is therefore a significant place for research of this nature in developing a critical consciousness within the institution of nursing and knowledge for critically reflective practice.

Concluding Statement

Through the use of a socially critical approach this study has demonstrated the ways in which the socio-political knowledge structures of the institution may serve to constrain the actions of nurses and prevent them from exercising personal and professional agency. If nurses are to practice effectively, in ways that reflect the professional ideals of autonomy and accountability, then they must find ways to overcome such constraints. Coming together to engage in socially critical self reflection may enable nurses to surface and challenge the ideological understandings that perpetuate existing, repressive social relationships and practices. In this way new possibilities for transformative action may be developed.

APPENDIX

APPENDIX

INFORMATION FOR WARD STAFF

My name is Pat Hickson. I am a Registered Nurse at present working towards a Master of Arts degree with a major in nursing at Massey University.

Over the next few weeks I will be spending some time in your ward observing nurses at work and examining the charts of a small number of patients and some related documentation. I am interested in the broad area of information exchange between nurses and patients, particularly in surgical wards, and seek, in undertaking these observations, to gain some understanding of these processes in your particular ward area.

I will be approaching personally each patient whose chart has been selected for examination and each nurse or patient who may be affected by the observations to gain their permission.

I wish to emphasise that I shall not be collecting any personal or identifying information about any patients or nursing staff, that no personal evaluation of performance is involved and that, other than having obtained their permission to undertake the study, I am completely independent of hospital management.

As this is an exploratory phase of a broader study in which some of you may be asked to participate it is unlikely that any immediate findings of significant interest to ward staff will result from these observations. However, if you wish to ask any questions about the study and/or its findings I will be happy to discuss them with you at any time.

My contact address is:

c/- Nursing Studies Department,
Massey University

and my home telephone number is Linton 505

Thank you in advance for your assistance.

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